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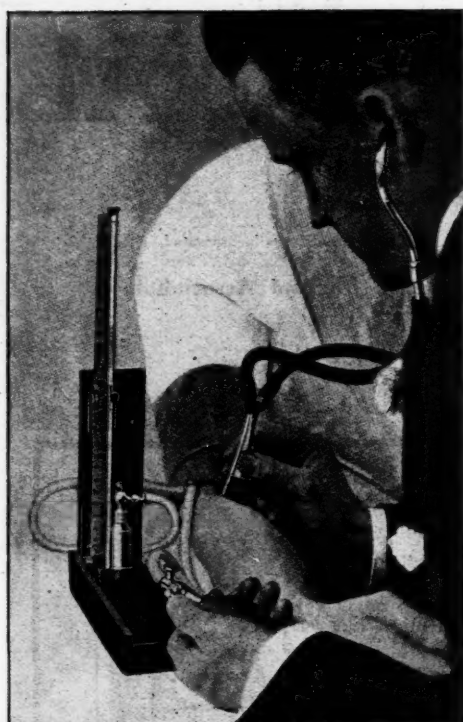
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No. 15.

THE WORK OF A CASUALTY CLEARING STATION.

By **Archie L. McLean, B.A., M.B., Ch.M. (Sydney),**
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From far away distance, in a clime where all seems care-free and sun-bright, it is strange to draw a picture of sordid, ghastly war. And so the strangeness and the contrast were more insistent and acute, the horrors starker, the details more brutal, amid the fair fields of France in the month of July, 1916. The picture, be it ever so faithfully limned, may stand warm and vivid, arresting and bold in the vista of imagination; but it is, after all, a pale experience beside a throb of the actual fact.

A cold, grey morning on the undulating downs behind Arras: a gusty sou'-westerly breeze driving big banks of cumulus across a sky of twisted wrack: the pastures fresh and the farmlands greening towards harvest. Near the rustic bridge of the hospital swaddled in a heavy greatcoat, walks the orderly, holding a restless cane in a bemitted hand. He does a regular beat past the Reception Tent across the fairway to the Orderly Room, varying the forward-and-back with a saunter to the bridge, where he leans on a sapling rail and gazes down the clay-brown road through the gates of the level crossing. Away beyond that group of silver poplars, aslant to the prevalent wind, he follows with a mechanical eye the white road winding on to that village steeple shooting up from environing oak and elm. A speck has filled the white avenue of distance, and he idly wonders what it is. Already since daybreak he has seen a convoy of ammunition wagons going east, and hard on its heels a scurrying fleet of supply lorries; and in lumbering, noisy deliberation a traction-engine with a nine-inch howitzer in tow.

Down the straight, passing close to the old *estaminet* at the level crossing, comes a speeding automobile with the familiar canopied front of an ambulance. Instead of dashing straight towards the Arras road, it turns on to the beaten clay and draws up before the orderly, who has advanced from the bridge to receive it.

The first casualty! The orderly has run to the Reception Tent to awaken the stretcher party on duty; while the driver, enveloped in a fur-lined leather coat, climbs down from his corner seat, stamps his torpid feet and beats vigorously together his hands, clad in a pair of lamb's skin mitts. The stretcher party, under the goad of a sleepy and irascible corporal, turns out of warm blankets into the chill embrace of the morning air. The driver accosts them cheerily, and tells them to handle their man carefully because he is seriously wounded. No need to tell them that! The stretcher slides gently on its runners from the interior of the ambulance, and 4053, Pte. W.J., 2nd London Regiment, is lowered to the ground.

His face is ashy and pinched with cold, his eyelids flicker and he looks drearily around, with a pathetic hint of dazed resignation: "I am still in the Army: these fellows are doing the best for me!" The face looks through the visor of a woollen Balaclava helmet caked with yellow mud. His torn tunic showing above the dark blankets is stiff with dried plaques of mud. On his slow-heaving chest is a waterproof envelope edged with red—the "field medical card." The blankets are piled high over his left leg, and the iron rods and cross-piece of a splint project below the canvas at the foot of the stretcher. The splint has been lashed immovably to one of the handles; and there is trench mud in brittle layers over poles, handles, canvas, runners and traverses. The man has come straight from the firing-line on this stretcher. The regimental doctor probably immobilized his shattered leg with a padded rifle. Then, when he arrived at the field ambulance, he was given a touch of anæsthetic, the wound was cleaned up and dressed, and a Thomas's splint was fitted.

Two bearers, with a slow, stooping gait, cross the bridge and mount the grassy bank in front of the Reception Tent. They push through a canvas-walled vestibule and stop to put down their burden on the dark tarpaulin floor of a gigantic tent, empty but for a table of dressings and a few neat piles of blankets and stretchers at precise distances around its wide girth. Here they await the arrival of the Orderly Officer, whom one of the party has gone away to fetch. Then another bearer staggers in with a rifle and a pack stuffed with miscellaneous equipment.

It is five minutes before a figure buttoned up to the neck in a ponderous overcoat comes sloshing through the rain-drenched grass in a glistening pair of gum-boots. Approaching the soldier, he notes the livid pallor, the slow, soft pulse, the gelid, clammy hands, the pupil narrowed by morphine. He undoes the waterproof envelope tied to one of the coat buttons, and takes out the field medical card to read, "Multiple shrapnel wounds of legs and back, fractured left tibia and fibula. Anti-tetanic serum, 750 units." He has already been apprised of the fact that anti-tetanic serum has been given by the —th Field Ambulance, in a conspicuous T marked in indelible pencil on the soldier's forehead.

"Send him along to No. 2 Ward; I'll just go and tell Sister what to do for him!" from the Orderly Officer.

"Give him plenty of hot bottles: put him on a rectal saline: I want him to retain as much as possible: give him 1 c.cm. of pituitary extract. I don't think he will need any more morphine for a while, but if he seems in any sort of pain give him a quarter of a grain. Poor beggar, he seems to be suffering from a good deal of shock. We'll just let him settle down for a while: we may not get him

along to the theatre until after lunch. . . . No, don't touch his dressings, just let him keep warm and take the saline: he has had a lot of knocking about since he left the trenches last night. If he is able to take something by mouth give him warm milk, weak tea and things like that!" from the Orderly Officer to the Sister.

In the new tent-ward the sister and the orderlies have received at last their first patient. The Orderly Officer stands by and superintends his transference to a new stretcher; snipping through the bandage lashing the splint to the handle and gently lifting it from its bed of blood-soaked canvas and gory, pultaceous trench mud into a horizontal position. Meanwhile the sister and the two orderlies are removing tunic, trousers and equipment, piecemeal, with many rough tears through the khaki ingrained with powdery dust, with many bold hewing cuts through leather straps and webbing braces. He is stripped to his dirty underclothing; the outer khaki and the odd jumble of leather belting and ammunition pouches have been laid back on either side. He is lifted gently, ever so gently—the doctor in charge of the splinted leg—upwards, while the orderlies draw away the rags of his uniform, the strapping, and the bloody rubble of clods and mire. The soldier groans. He is moved gently—a sorry, maimed body in tattered woollens, legs and hips swathed in bandages ruddy with blood and stained with the universal mud—ever so gently across to a new stretcher, into a bed of blankets warmed by bottles and whitened with the refinement of two calico sheets. The doctor lowers his splinted leg on to three brown Army pillows, while the sister and orderlies commence to divest him of the singlet and to sponge over with soap and water his flaccid limbs and body. He groans as the splint sags deep into the pillows. The doctor walks off with a few parting instructions to the sister: "Let him keep as quiet as possible: I want him to have plenty of saline: what he needs is a good rest. I'll come back after breakfast and see what he's like: we'll probably get him into the theatre this afternoon: if his pulse goes off, send for me straight away!"

At nine o'clock the doctor walks down the long aisle between the waiting stretchers to the dressings' table, opposite which are two screens enclosing the stretcher bed of 4053, Pte. W.J., 2nd London Regiment. A douche-can hangs from the top rail of one screen, and a long piece of tubing passes down and is lost between the blankets.

From the sister: "He has taken a pint and a half of saline since six o'clock, doctor. I gave him the pituitary: his pulse is much quicker, but stronger. It was a hundred and fifteen when I took it last. He has been sleeping splendidly all the time, and I didn't need to give him the morphine. I didn't disturb him, either, to give him the nourishment."

"That's all right. Yes, his pulse is much better. He looks another man: that ashy grey colour is all gone. He is quite warm and ruddy. A big healthy fellow—it takes a lot to kill these chaps. The fracture wound has been oozing a bit? Put some more cotton wool on it and bandage it—not too tightly! I'll go and tell the theatre sister that we'll have him

in at two o'clock. He could do with some more saline. I'll come along again soon, sister!"

By two o'clock the primus stoves in the white operating hut had finished roaring. There is a brisk bubble and escape of steam from the long, metal sterilizer standing over the flaming spirit lamps. The sister, close by in her white gown, lifts the cover and, amid a rush of steamy vapour, picks up the inner tray with handles and empties a modest heap of instruments on to a sterile cloth covering a small trestle-table. The white-gowned orderlies, their preparations all made, stand at the door looking for the first patient and listening to the heavy booms of the howitzers. The glass panes rattle as the great explosions break out fearfully into the silence; the sixty-pounders and the field guns nearer the trenches thudding flat and dull through the souging sou'-wester. "The big push will be starting soon!" they say.

The patient arrives on his stretcher, the surgeons appearing just in time to help the orderlies lift him on to the operating table. The anaesthetist is soon in his gown, folding a strip of gauze, which he fits on to a mask. He makes a mixture of ether and chloroform, and, after weeks of digging, tent-pitching and carpentry, addresses himself to a once familiar task, seated on a stool of piled-up boxes. The paraphernalia of bottles, gag and forceps are huddled together at his side. The surgeon specialist looks through the few glistening instruments—scalpels, dressing and artery forceps, retractors, scissors, amputation knife, saw and bone forceps—and the tray of ligatures and needles. He notes the table on which lies the case of instruments and a dish of carbolic lotion next to it on an upturned box. He chooses a Thomas's splint from the heap in the next room, brings it into the theatre and joins his two assistants "washing up" in the row of steaming basins on the bench.

The orderlies have a long task removing the soaked and dried bandages from the patient, now insensible. The surgeons, in their dripping gloves and spotless gowns, look on and give directions. The splint is cut away and the wound at the site of fracture exposed.

At first sight a jagged, fenestrated opening, right through the middle of the left leg. Tibia and fibula shot away and fragments of bone in chips and shivered spikes protruding from torn, reddish-brown lumps of muscle. Anterior tibial artery severed, the interosseous membrane non-existent, posterior interosseous artery gone, and a slender bridge of muscle on the outer side of the leg carrying a feeble blood supply! It seems wonderful that this soldier did not die of hæmorrhage. The foot still warmish; but the bones above and below the wound are badly comminuted and split longitudinally. Exploration brings much black blood-clot out of a deep interstices tracking down along the posterior tibial vein. A frayed wad of clothing is impaled on the broken shaft of the tibia. Surely a case for amputation with such gross, widespread and inaccessible infection! Against that is the resistance of the patient; pulse-rate 115, temperature 100°, no sign of infection by gas-producing organisms! But here is

a case of multiple wounds. There are at least three pieces of shrapnel imbedded in the right leg, and the left thigh and buttock and the lumbar region are studded with seared perforations; some of those wounds in the back may be abdominal. He will do well to throw off this infection, suffering as he is from profound shock; and even if that hole in his left leg ever filled in, what use would the leg be to him? It is not worth risking the man's life, subjecting him to the onslaught of all the bacteria that would multiply in that mushed and mangled wound; faecal bacilli of all kinds, streptococci, staphylococci, and probably one, if not all, of *bacillus tetani*, *bacillus maligni oedematis* and *bacillus perfringens*. They have had no time yet to become apparent: the man was only wounded last night!

The amputation is speedily done at a site three inches above the wound by an almost circular cut; the bone alone is sawn through an inch above the incision. The open wound is swabbed out with hydrogen peroxide and bound up, with a dressing of gauze soaked in eusol.

The patient, who takes open ether very well, is turned over, and two surgeons get to work. The multiple wounds are sliced open freely, and, in some cases, where the track of the missile can be followed with certainty, scissors are used to make a track through the muscles and large rubber tubes are inserted and secured to the skin by silkworm gut ligatures. All wounds are washed out with hydrogen peroxide and filled with gauze soaked in either eusol or hypertonic saline solution. There are adherents of the efficacy of both dressings in the surgical staff of a clearing station.

The procedure is simple. The mixed bacterial infection is of the greatest import. Never mind about the bullet or the piece of shrapnel—they will locate these by radiogram at the Base. Let out the infection by a deep and, maybe, wide cut. But new tissue will be infected, and the wound will take weeks to heal? True, but drainage of the bacterial toxins come first—a very special and deadly infection, unique in the annals of war!

Wounds vary a good deal. There may be several alongside one another on a thigh, a buttock, in the back. Some penetrate, some perforate. It might be worth while joining up several of the penetrating kind, uniting them in a deep, irregular, cavernous, niched hollow, out of which has been excised, perhaps, fragments of discoloured muscle, strands of sodden clothing and twisted leaves of high-explosive shell. Attack a perforating wound at both ends by exaggerating the entry and exit; then thrust through it a tube which slides easily, and secure this by a ligature at one end. The wound will be healthy by the time the soldier arrives at the Base. If the tube in its course impinges on a large artery or vein, it is best to insert a tube from each end down to the vessel in question.

Perforating wounds often go through a limb, missing the bone, chipping off a section of it, or cracking, seaming or destroying it in a fashion which makes every instance unique and a thing to be treated on its own specific merits.

The question of amputation when joints are infected is one which makes the surgery of the limbs a problem where wide experience, sane judgement, scientific dictates and common humanity are often nicely balanced.

Abdominal wounds run up a high mortality at a casualty clearing station. Bullets often pursue a tortuous course between intestinal coils, causing no symptoms beyond the inconvenience of the wounds of entry and exit. When fired at close range, their concussion effects on solid organs like the liver, kidneys and spleen may be very extensive and fatal. From the same cause, too, the intestines may suffer irreparable damage, and death be the result. Pieces of high-explosive shell and jagged shrapnel usually do not enter the abdomen without tearing the gut and making the prognosis very grave. The type of peritoneal infection, whether it be from the colon, rectum or small intestine, modifies the prognosis in a marked degree.

One is led at a clearing station to view thoracic wounds from a favourable standpoint. Doubtless many men die on the field of battle, shot through the heart or great vessels. But scores of soldiers arrive with perforating thoracic wounds who, after a few days, a week, or more—as the exigencies of "clearing" demand—go down in a sitting posture on an ambulance train to the Base. There, pyo-thorax or pyo-pneumo-thorax may often fatally supervene.

Men who escape from the disordered sea of bullet-swept trenches with wounds of the face or neck, unless the damage is very deep and extensive, usually pass through a clearing station and, during their short stay, have dressings changed several times. The increased blood supply will often deal with the infection, though, of course, many have died of secondary hæmorrhage at the Base or in England.

Wounds of the brain and cranium have provided many of the "nine-day wonders" of war surgery. But the after-history of numerous miraculous cases awaits to provide the full story. Radical decompression by extensive removal of bone has its adherents, while there are extremists in the other direction. At a hospital in the field, when penetration of the inner table and *dura mater* has occurred, one can do much by shaving and cleaning the skin around the wound, incising deeply, removing loose pieces of bone and, perhaps, if there is opportunity, securing shell fragments; supremely, by promoting a free and efficient drainage outwards. Cases of spinal concussion or injury of the spinal cord, with accompanying paralyses or pareses, usually remain with a field hospital till they are fit to be moved.

Generally, one seems to gather, how deadly it is to leave an unopened pocket, a deep infected recess behind a muscle, a widespread internal disintegration with a minute aperture for discharge; how eminently satisfactory it is to have a wound open to light and air, even though in a few days it may be yellow with sloughing muscle or smeared with the discharge from a track at whose bottom lies the offending shrapnel. But the subject is too immense. The hospital in the field take account of the tenets of radical surgery and the dictates of the Army.

There were gigantic salvoes from the guns all through the night of June 30th, and soon after the burning sun had lifted out of the east there was an ominous silence. Then came an outburst from the enemy, who had withheld his fire; then the crashing response, till a mighty duel of thunder had begun, which made our huts tremulous, and set the panes of glass rattling in their frames. It was the first of those wild bayonet rushes, of that methodical advance over the stricken field of the Somme.

A few hours went by. Along the white road winding past the silver poplars to the village steeple amid the trees came the first convoy of racing ambulances, the dust-clouds wafting off the highway over the shimmering fields of barley. Wounded soldiers, walking, hobbling, limping—the halt and the maimed who had been caught on the parapet by the winging hail from machine gun, rifle and shell. They had fallen, crawled and clambered back into the front trench out of the desolating fire. Then, gathering themselves together, they had made off down the interminable *boyaux* which lead backward to safety. Safety? But not yet! The barrage of bursting shells breaks over the network of the trenches in reserve; a deadly curtain to envelope the waves of reinforcing infantry hurrying up to the front line. The racked and wounded wretches crouch in stray dug-outs and miserable sump-holes, waiting for the storm to pass. Many are mortally stricken half way down the road to life; many win through to an advanced dressing-station, and, in a kind of dazed and trembling delirium, take their seats on the crowded ambulances. Cigarettes are passed round and a flood of pent-up happiness breaks out in the first thoughts of home, in the supreme glory of being a wounded man.

We have two large tents and a French hutment for the "walking wounded," as the Army styles them. Their wounds are dressed, if necessary; they are ticketed anew, perhaps, and sent off to a long line of trestle-tables for tea, bread and other refreshment provided by the Quartermaster. Then the crippled crowd are herded together down on the platform of the railway siding where the hospital train has been waiting since dawn. The carriages fill up as the afternoon lengthens, and then the hospital train steams out, soon to be replaced by a second one, which pushes into the siding to find another ticketed, bandaged, mud-daubed throng waiting on the platform.

But the clearing station is now hard at the solid work. The "lying wounded" are arriving in shoals; battered heads, mangled limbs, bodies holed, shattered and torn in the resistless blizzard, under the lacerating flail wrought by the engines of war. In the wards the surgeons thread their way between the stretchers labelling with two tickets; a red one denoting "to be evacuated at once," a white one signifying "not to be moved." In the second class are many of the hopeless, moribund patients for whom operation would be futile, and these are grouped behind screens at the far end of the wards. The labelling has to be done as each fresh batch of wounded arrives, for the clerks of the orderly room and the stretcher bearers are then aware of the cases

to be carried off to the train. And all the time there are ghastly dressings to be done, splints to be affixed anew, morphine and stimulants to be administered, food and drink to be given, and the many pressing wants of the patients to be satisfied. Doctors, sisters and orderlies scarcely know where to turn; they are most successful if they are methodical.

There is a lull in the arrival of wounded, and a rush of the doctors to the theatre. The surgeon specialist has been busy all day, with the dentist for his anaesthetist. Five abdominal cases and three trephines so far, and three of the former patients have already died! It all seems a hopeless shambles, but we go on filling up the hospital trains with the living; the dead are carried silently away to the cemetery, full of open graves, ready for the battle.

The rush is over in three days, during which more than two thousand wounded soldiers have passed through our hands. We settle down to steady, ordered, useful work, with a prospect of a good return for our labours.

THE IMPORTANCE OF EARLY DIAGNOSIS IN PULMONARY TUBERCULOSIS FROM A PUBLIC HEALTH POINT OF VIEW.¹

By A. Stewart, M.B.,

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As a result of the increase of our knowledge of various conditions in the course of disease, preventive medicine has now assumed a position of importance in public opinion. The frequency of this disease, as well as the sad after-effects, afford every excuse for writing this paper.

Of late years so much has been said and written about the newer forms of treatment that this has more or less overshadowed the necessary subject of diagnosis. It is obvious that success depends on the early employment of such therapeutic measures, and to insure this implies early diagnosis, so that good results may be reasonably expected. The failure to diagnose tuberculosis in its earlier stages is a widely spread evil, so much so, that it may be safely said the whole profession all over the world has failed in its duty in the past. In many instances the patients are to blame by not seeking advice sooner; other patients, fearing the worst, go from one doctor to another with the faint hope that they may meet one who will tell them they have not got the disease. It must be admitted that many practitioners, out of mistaken kindness, lull their patients' anxiety into a false security by using such expressions as "weak blood vessels," "weak lungs," etc. The whole subject of diagnosis assumes fresh importance, in view of the sanatoria which are being erected all over the world as a direct result of the universal interest taken at the present time in tuberculosis. In view of this, it is our duty to make the best use of our opportunities, and not to be satisfied with the recognition of obviously plain cases, but always to be on the alert for the very earliest mani-

¹ Read at a Meeting of the Queensland Branch of the British Medical Association on March 2, 1917.

festations. The conclusion is unavoidable that many of us have failed to utilize our opportunities in diagnosis, or, what is more common, have avoided the disagreeable task of informing patients of their actual condition. In my experience they receive the verdict with calmness and fortitude when the trouble is told them in a straightforward and kindly way. Certain it is that so-called education of the public in the disease of tuberculosis avails nothing unless the profession be so educated as to recognize the disease when consulted. Medical schools must send out graduates well versed in its recognition; they must be thoroughly imbued with the great importance of this recognition; the responsibilities of their patients' future life rest on them alone. The real issue of this lies on us as a profession, and must not be over-clouded by the so-called philanthropy of societies for the suppression of tuberculosis, by popular lantern lectures, and other anti-white plague tactics. These measures may possibly be useful in a limited way; but this usefulness is altogether eclipsed by the ulterior results due, I admit, to ignorance. So much is this so that I feel sure in many cases the crusade against consumption degenerates into a crusade against the consumptive. I feel very strongly in this matter; some of my patients, who, I have every reason to believe, were distinctly cured, have had the greatest difficulty in procuring employment, and on several occasions have asked me to give a negative answer if written to concerning their residence in the sanatorium. With such advanced propaganda, does it not seem absurd that many of our profession cannot, or will not, diagnose pulmonary tuberculosis? The only philanthropy worthy of the name, and that most needed, is a great number of practitioners who will be able to diagnose early cases, or who, at least, are able to recognize their responsibilities and see that they are diagnosed. A goodly percentage of advanced cases have sought medical aid in the early stages, and, making all allowances for the fickleness of wayward men, it must be admitted many such infections could have been arrested if the diagnosis had been made promptly, and that many of these lesions would have remained closed from the beginning, and, therefore, naturally only a limited few would have ended as foci of infection. I maintain that this end will be furthered more by better education than by florid propaganda, the ultimate results of which are only scare producing. I may suggest here a few plain words on infection and infectivity might clear up matters.

It is not within the province of this paper to discuss signs and symptoms that obviously point to tuberculosis; still, I may be allowed to remark that justifiable mistakes may be made in being misled by vague symptoms of ill-health or the result of slight tuberculous toxæmias, such as dyspepsia and vomiting; this feeling of continuous ill-health, with no cough, is not sufficiently suspected nor recognized, and is often called being "run down"; in such cases, in the absence of disease in other organs, persistent and steady loss of weight should never be lightly dismissed: there is usually some other sign, such as hæmoptysis or irregularity of tempera-

ture, which may be the means of making a positive diagnosis possible. Many cases of so-called influenza are sub-acute pulmonary tuberculosis from the very start; and long-drawn-out cases of unilateral broncho-pneumonia are gravely suspicious. All other causes being carefully excluded, pulmonary hæmorrhages are due to tuberculosis only, and ought to be looked on as a heaven-sent gift to the diagnostician. A great deal too much weight has been put on the absence of tubercle bacilli from the sputum; as a rule their presence is really a late sign. A negative result is generally the rule in early cases. "Absence of proof is not proof of absence."

The physical signs are, as a rule, slight, but are rarely indefinite, and can usually be found if critically looked for. They are, in the order of their importance, auscultation signs, impaired respiratory movements, and percussion signs. Before applying these, a clear conception of what is actually present in a healthy chest ought to be thoroughly appreciated. This, at the present time, is not taught as it ought to be; it is not mentioned in Sahli's "Diagnosis," which is recognized as a standard work, nor in a well-known "Edinburgh Students' Manual," and is only curtly mentioned in Finlayson's book. The most complete account is found in the late Dr. Austin Flint's book on "Physical Diagnosis." As a result of this imperfect teaching, many students leave their *alma mater* with a vague notion as to how deviations from the normal should be properly assessed. Auscultation and impaired chest movements are well discussed in text-books. Contrary to the usual teaching, I have never found voice sounds much of an aid; whispered sounds are more useful. Accentuation of the heart sounds on the suspected side is worth noting. Light percussion has been put forward of late years as a new sign, principally by Pottinger, of America, and Dr. Clive Rivière, of Victoria Park, London. This method was ably advocated by my revered chief, Sir W. T. Gairdner, and was taught by him in the Edinburgh Royal Infirmary, while he was yet a very young man, before his transfer to Glasgow. If cases be carefully examined, tuberculin tests will hardly ever be required. Owing to the prevalence of eye disease in Australia, Calmette's test is not applicable, and von Pirquet's test in adults is unreliable. The subcutaneous test can only be used in a limited number of cases. The temperature must be normal, a condition found very rarely in tuberculosis, if practitioners can be prevailed on to use the rectal method. Roepke's schedule is the one commonly in use, consisting in a possible series of injections of old tuberculin, commencing with 0.2 c.mm., 1 c.mm., 3 to 5 c.mm., and the maximum, 10 c.mm. The rectal temperature must be taken two-hourly, when a rise from one to two degrees may be looked upon as a positive reaction. The value of the test is based on two reactions, the focal and general. The former is of greater importance. A general reaction means tuberculosis somewhere; a focal reaction means the excitation of an actual tuberculous deposit in the suspected lung. After each injection the lungs must be carefully examined; if even a minute focus is found,

although there be no temperature rise, further test injections must be discontinued, as continuance will be harmful. My experience of this test extends over more than fifty cases, and the conclusions drawn therefrom convince me it is safe if carefully done in selected cases.

Leaving out the presence of tubercle bacilli, a special pathognomonic sign does not exist. Those who seek one may be compared to the Pharisees of old, who "sought a sign and no sign shall be given." The diagnosis must be made on the consideration not only of the signs, but of the symptoms also. Persistent symptoms, even in the healthiest-looking man, should always be looked on as serious. Failure to examine the sputum in such cases is inexcusable, though a negative result means nothing. It must never be forgotten that prognosis in a case where tubercle bacilli are consistently absent is infinitely better than when they are present; that the disease is much more extensive than the signs indicate; and, lastly, it is not only a pair of lungs you are examining, but a man who can talk and describe his symptoms. I trust I may be excused for mentioning, even in a sketchy way, the chief signs and symptoms, but it seems in a measure essential that these should be given, so as to constitute a sufficient introductory picture for the early diagnosis of this disease.

It is well within the scope of this paper to discuss why we have failed to train ourselves to take advantage of all the facilities given to make an early diagnosis possible, and with the present tendency of over-caution, there is no danger in giving undue importance to signs and symptoms. There is not much harm done by being over-careful, as the results at stake are so awful as to make needless delay inexcusable. As I have already stated, early diagnosis is the first step towards clearing the way, so that an effective campaign may be initiated by Health Commissioners and other Government officials. The onus of this must be taken up by us as a profession, and us alone, for it is the advanced case with bacillus-laden sputum, which is a menace to the community. We can at least do our duty to our patient, and show thus to the public our ability to make an early diagnosis, and to state fearlessly our convictions in accordance with our highest ideals.

Reviews.

THE ART OF ANÆSTHESIA.

Our American confrères are displaying characteristic energy in anæsthetic matters. This has been manifest for some time past in the many new methods and appliances emanating from that country. Since the inauguration of their Society of Anæsthetists and its Journal (published with every fourth issue of the *American Journal of Surgery*) an impulse has been given to the literary phase, with the result of greatly increasing the volume of printed matter issued. Flagg's book¹ is a reflex of this. He is somewhat original in his manner of presenting the subject, extensive personal experience being largely responsible for his author-

ity. Originality of description is observed throughout, much of the stereotyped expression of the older standard works being discarded. A combination of clearness of definition and conciseness has been achieved by the assistance of many illustrations. It marks the advancement level of anæsthetics in the States.

The brief history, in the introduction, adds some material to that already published; interesting letters are reproduced, and four portraits are given, in which Dr. C. W. Long, who opened the anæsthetic period of ether, is grouped in company with Homer and Shakespeare.

Flagg insists that the would-be master in the art of anæsthetics must have an intimate knowledge of general medicine, pathology, surgery, physiology, as well as of some of the special branches.

After detailing preliminary preparation and examination of the patient a concise exposition of induction, maintenance in and recovery from general anæsthesia is given, together with crisply detailed descriptions of the indications for guidance, of the danger signals and the means of avoiding them. Then follows a comprehensive description of the uses of ether by the various methods—open, closed, intrapharyngeal, intratracheal, colonic, nitrous oxide with oxygen and ether, and intravenous. A resumé of the relative advantages of each is given at the end of the chapter. The colonic method is regarded with scant favour, and on the other hand the N_2O , O_2 and ether method is evidently that most favoured by the author. A chart is given, showing the results, in detail, of anæsthetizing 100 patients by this method. It shows incidentally that morphine in $\frac{1}{4}$ gr. doses is commonly employed for preliminary medication. This is in excess of that employed in routine in Australia. It would also lead one to infer that American surgeons are satisfied with a lighter level of anæsthesia than that in demand here. The subject ether occupies considerably more space than that of any of the other agents.

Chloroform is less extensively dealt with, and the physiology given is somewhat faulty in places. The uses, methods of employment and advantages of ethyl chloride, nitrous oxide, nitrous oxide and oxygen are clearly and adequately given. The article on mixed or spinal anæsthesia is well done, the description of the proceeding being supplemented by six fine illustrations. Local anæsthesia is also fully set forth. Articles on preliminary medication, emergency anæsthesia, the use of the aspirator, post-operative treatment, the patient's point of view, and on re-breathing and CO_2 are in keeping with the general excellence of the work. The article on re-breathing and CO_2 should be carefully studied by every anæsthetist.

The book is clearly printed on special paper. It is a welcome addition to the standard literature on anæsthetics.

SURGICAL ANATOMY.

Macewen's Surgical Anatomy is a concise book² on the subject, consisting of over 500 pages and 77 illustrations. The bearing of anatomical facts and the physiology of parts on surgery is well emphasized. In the discussion on hernia the anatomy has been considered from the abdominal aspect, and this appears to make the condition easier for the student to grasp than the ordinary description found in the majority of text-books.

Possibly more illustrations would be of advantage; but the author's object has been to keep the work within small compass. It can be recommended as an accurate textbook to students and practitioners.

It has been announced that the Commonwealth Government has entered into an arrangement with the Red Cross Society and with Mrs. M. S. Hall, of Mount Morgan, South Australia, for the erection of a special hospital for returned sick Australian nurses. Mrs. Hall has generously offered to provide the necessary funds, while the Red Cross Society will provide various equipment. The staff will, presumably, be under military command.

¹ The Art of Anæsthesia, by Paluel J. Flagg, M.D., 1916. Philadelphia and London: J. B. Lippincott Company; Demi Svo., pp. 341, with 130 illustrations. Price, 18s. net.

² Surgical Anatomy, by John A. C. Macewen, B.Sc., M.C., C.M., F.F.P.S. (Glasg.); Second Edition; 1916. London: Baillière, Tindall & Cox; Demi Svo., pp. 505. Price, 10s. 6d. net.

The Medical Journal of Australia.

SATURDAY, APRIL 14, 1917.

A Moral Obligation.

It is becoming increasingly evident that the medical profession will be required to redouble its efforts within the next few months to satisfy the requirements of the military authority. The foundation for that special effort has been laid, and the superstructure can be erected without great difficulty, provided that the work is undertaken in a proper manner. A builder does not erect a house without the plans carefully drawn up by the architect. So the medical profession cannot construct a durable and useful machine to provide medical attendance for the military and for the civil communities without a carefully organized plan of campaign. On a small scale, the profession has been organized in a manner wholly suited to the present emergency in South Australia. Unfortunately, even in this State there are certain limitations. Every medical practitioner under 45 years of age, with the exception of those of German origin, and a few who for one reason or another are regarded as being unsuitable for military service, has obtained a commission in the Australian Army Medical Reserve. The District Medical War Committee has the complete confidence of the profession, and the civil and military needs are satisfied, after due consideration has been given to the local conditions and to the work that has to be carried out. In New South Wales a movement of extraordinary energy has been developed, and a large number of practitioners has recently obtained commissions for home service. In Queensland the organization of the profession has made considerable progress during the course of the war, and the Council of the Branch of the British Medical Association has been able to watch the development of affairs. At the present moment it is felt that a little more may be done in Brisbane, and possibly in the

country districts and towns. In Victoria there has been a good response to the call for men to join the Reserve, although there are still very many who prefer to remain outside. Similarly, a considerable amount has been done in Western Australia and Tasmania. But when it is all summed up, the medical profession should not rest with the satisfied feeling that it has done more than any other section of the community, and that there is no need for any desperate output of energy. Until every suitable medical man in the Commonwealth is available for duty at home or abroad, the medical profession has not fulfilled its duty to the country. Then, and not till then, may we be satisfied that we have reason to be proud of the fruits of our efforts. At the same time, as this endeavour to do the right thing for the Empire is being carried out, the members of the medical profession should recognize another moral obligation; an obligation to those members who may become incapacitated as a result of having served with the Australian Imperial Force.

In *The Medical Journal of Australia* of March 10, 1917 (page 218), Dr. Frank S. Hone has dealt with this matter in some detail. Unfortunately, no one has sought the opportunity of discussing the proposal, and of developing a practical scheme to give effect of his suggestions. With the proposition that medical practitioners who become handicapped in the struggle for existence, as a result of either illness, unwonted strain, or wounds, should not be permitted by the more fortunate members of the profession to languish, no one will disagree. How to provide for these and similar exigencies should engage the attention of the mass of the medical profession in the Commonwealth. There are many difficulties and pitfalls. Any assistance extended to our colleagues in this unfortunate position must not be tainted with the savour of charity, and must not be so meagre that its value is questionable. It would appear that some form of contributory fund to which the men going on active service could subscribe would be the best means to meet the difficulty. It would probably not be possible at this date to inaugurate an actuarial scheme, although an insurance against partial or complete incapacity in practice would be highly beneficial, both for the insurance companies undertaking the risks and for

the medical practitioners making use of this class of policy. The premium could be kept at a low figure if first year medical students could be induced to take out the policy. But for the purposes of incapacity occasioned by the war, a contributory or non-contributory fund appears to be the only immediate solution. That this fund should be a large one, and that it should be Federal and not State, scarcely needs discussion. It would be of practical advantage to the profession, if suggestions were put forward concerning the means of carrying the idea into effect. This Journal could be used for the purpose of establishing the fund in the first instance, until a substantial sum could be handed over to a properly elected committee for investment and distribution.

THE ENTERICA AND ATROPINE.

The opportunity afforded by the war for the study of various infections involving the intestinal canal has led to the determination of many facts, even if it has brought some confusion, by illuminating several indifferently understood phenomena. In particular, much sound work has been accomplished in connexion with the group of diseases, sometimes called the enterica. Among these highly important and interesting investigations the differential diagnosis between the various forms of infective jaundice may be regarded as claiming a prominent place in our attention. Under ordinary conditions, the distinction between the three diseases, enteric fever, paratyphoid A. and paratyphoid B. fevers, the agglutination reactions associated with the name of Widal suffice. But when the patient has been subjected within a short time of the onset to a protective inoculation, the differentiation becomes less easy. The isolation of the causal bacillus cannot always be attempted, and even when facilities exist for this investigation, the procedure is not usually suitable for the purpose of arriving at a clinical diagnosis. Recently, Captain Marris, R.A.M.C., has noted that the rate of the heart's beat does not usually respond to the accelerator action of atropine during an attack of one of the enterica. Normally the number of beats of the heart in each minute is increased by from 20 to 25 after an injection of 2 milligrams of the sulphate of atropine. The increase is noted some 15 to 20 minutes after the injection. Captain Marris has found that the heart beat failed to increase in rate during a variable period in the course of an attack of enteric or paratyphoid fever. In Weil's disease, more aptly called spirochætal jaundice, the acceleration takes place as in the normal subject, and the same applies to catarrhal jaundice, and also to other forms of infective jaundice. There is no information avail-

able as to whether the heart beat is quickened in yellow fever by the action of atropine. Captain Marris has suggested that the toxins of the bacilli of the enterica group block the nerve endings in the heart, so that the atropine has no opportunity to effect its action on the cardiac muscle. There does not, however, appear to be any evidence of a direct attack on the cardiac nerves by any toxins produced by the *bacillus typhosus*, or by the allied organisms. It is true that a profound effect on the heart is noted in severe infections, but this becomes apparent only when all the tissues of the body are affected. It is said that the failure of atropine to produce its physiological action on the heart is best marked between the eighth and the fifteenth day of the disease, and that the phenomenon may be evanescent. In the absence of direct evidence, it would appear to be more probable that the atropine in these cases enters into a chemical combination with some product of bacilli after disintegration. There is no true toxin in enteric fever, and the poisoning is produced indirectly by the products of the micro-organism. Whatever be the explanation of the phenomenon, its discovery is of importance, and further observations should be made, in order that its clinical significance may be thoroughly understood.

VENEREAL DISEASES ACT.

We publish in this week's *Journal* the text of the Act relating to Venereal Diseases which has become law in Victoria. The aim of this legislation is to enforce treatment by medical practitioners upon all persons suffering from gonorrhœa, gonorrhœal ophthalmia, syphilis, soft chancre, venereal warts and venereal granuloma. No person other than a medical practitioner can treat or supply any medicine for the purpose of cure to a patient suffering from any of these complaints under a penalty of a fine of not more than £50 or of imprisonment for not more than six months. The pharmaceutical chemist who dispenses the signed and dated prescription of a medical man is exempted from the effects of this prohibition. The chemist who sells any drug, except those forbidden by regulation, in the ordinary course of business without any intention of prescribing for a person suffering from venereal disease, is also protected from any penalty. A list of drugs and medicines which must not be sold by a chemist without a prescription has been prepared as a result of a conference between representatives of the pharmacists and the medical profession.¹

All persons who suspect that they are suffering from any venereal disease must forthwith consult a medical practitioner or attend at a hospital or clinic. They must furnish their correct names and addresses and submit to treatment. They must attend for advice and continue treatment until they receive a certificate of cure, under a penalty of a fine of not more than £20. When patients alter their places of residence or desire to change their medical attendant, they must at once obtain treatment and must inform

¹ See *The Medical Journal of Australia*, February 24, 1917, p. 168.

their new medical adviser of the name and address of their former medical attendant. The medical adviser must notify in the prescribed form the previously consulted practitioner of the change made by the patient. The parents or guardians of persons under sixteen years of age are responsible for the attendance and treatment of such children.

When a medical practitioner is consulted by a patient suffering from one of the diseases specified above, certain duties become obligatory. The practitioner must, within a time to be prescribed, send to the medical inspector of the Board of Health a notice in the form laid down by regulations. It is specifically set forth in the Act that this notice must not contain the name and address of the patient. The failure to notify is punished by a fine of not more than £20 for the first offence, and by a fine of not less than £20 or more than £100 on any subsequent conviction. In addition, the medical attendant must, in writing, inform the patient of the infectious nature of the disease and of the legal consequences of infecting others, warn the patient against marriage until he is cured, and give him certain printed information relating to the disease and to the duties of patients. In the case of children, their parents or guardians receive the directions and printed information. For a breach in respect to any of these obligations a penalty of a fine of not more than £5 is imposed. When any patient becomes cured or has ceased to be liable to transmit the infection, any medical practitioner may, on being satisfied of the fact and subject to the regulations, give a certificate that the patient is free from venereal disease or no longer liable to convey infection. When a certificate of cure has been received by a patient the liability to attend for treatment ceases. The issue of a certificate that a patient is no longer liable to convey infection does not relieve the patient of the necessity for continuing treatment. A penalty of a fine of not more than £50 may be imposed upon any medical practitioner who gives to any person such certificates, knowing them to be false in any material particular.

When a patient fails to re-attend for treatment as directed by his medical attendant, the latter must, within ten days, inform the medical inspector of the patient's name and address in a sealed envelope marked confidential. A penalty of a fine of not more than £20 for the first offence and of not less than £20 or more than £100 on any subsequent conviction is imposed for a contravention of this liability. The medical inspector is directed to warn the patient in writing to obtain treatment. If the patient does not attend for advice, a police magistrate may issue a warrant for the apprehension and detention of the patient for a period not exceeding four weeks in any hospital or ward of a hospital proclaimed by the Governor-in-Council as a place of detention. The patient must permit any clinical, chemical, bacteriological or other examination needful to ascertain the presence or absence of venereal disease. When the result of the examination shows that the patient is suffering from venereal disease, and the medical inspector after inquiry is satisfied that detention is necessary, the Governor-in-Council

may order the detention of the patient in a proclaimed hospital until such person is cured or no longer liable to convey infection. Any person so detained may apply to a judge or magistrate to be examined by two medical men, one of whom must be nominated by the patient. If the judge or magistrate is satisfied by the reports that the patient is free from venereal disease or is no longer liable to convey infection, he must order the release of the patient. Such an inquiry must be held in private, and an obligation of secrecy, under a penalty of a fine of not more than fifty pounds, is placed upon all persons present at the inquiry. A female patient can demand that she be examined by women medical practitioners, if such are resident within twenty miles and willing to act. A second application to a judge or magistrate may not be made by any person within three months of the first application. A medical man who gives without negligence a *bona fide* certificate in connexion with such an inquiry, is protected against any civil or criminal proceedings in regard to it. If the Minister of Health can be satisfied that any person undergoing detention is prepared to obtain advice and submit to suitable treatment, he may order the release of the detained person. Once in every three months all persons in detention must be examined by two medical men to determine whether they are free from venereal disease or no longer liable to convey infection.

Provision is made that any prisoner under sentence or any person in a reformatory may be removed to a proclaimed hospital and detained for treatment. The period of confinement in hospital counts as a part of the sentence, but the patient may be detained after the expiry of the sentence until cured. The prisoner may apply to a judge or magistrate to be examined, and the application is governed by the same conditions relating to other persons detained in a venereal hospital.

Any person knowingly infecting another with venereal disease or knowingly doing any act likely to lead to the infection of any other person, is liable to a penalty of not more than £100, or to imprisonment for not more than twelve months, or to both fine and imprisonment. Any person being the owner or occupier of a house to which a female person suffering from venereal disease resorts for the purpose of prostitution is liable to a fine of not more than £20 or to imprisonment for not more than six months, unless proof is established that the owner or occupier was unaware that the woman prostituted herself in a state of disease.

The Treasurer of Victoria may withhold the subsidy or any portion of it from any hospital not making effective provision for the accommodation, examination and treatment, free of charge, of such classes of persons, suffering from venereal disease, as may be prescribed by the Act. The Minister is given power to establish hospitals and clinics, to arrange for treatment by medical practitioners, and to settle the remuneration to be paid for such treatment, to provide chemical, bacteriological and other examinations free of charge to the patient, to supply medicines and appliances to patients unable, through

poverty, to obtain them, and to provide for the preparation and distribution of information relating to venereal diseases. The Governor-in-Council may make regulations, *inter alia*, with respect to the numbers and classes of persons eligible to receive free treatment at hospitals maintained by or receiving aid from the State, in regard to the fees payable to medical practitioners for notices given under the Act, and in relation to the periods during which according to the stages of disease patients must attend for treatment.

It may be advantageous to compare the provisions of the Victorian Act with those of the Act¹ which came into force in Western Australia in December, 1915, and which is similar in its general form to the Victorian Act. The earlier Act permits the registered pharmaceutical chemist to sell approved patent and proprietary medicines for the cure of venereal diseases. It also allows certain persons to sell such approved remedies in places distant more than ten miles from the business premises of a registered pharmaceutical chemist. Patients must obtain treatment within three days, but need not attend for treatment if they are more than twenty miles from a medical practitioner, or if they consult a medical practitioner by letter. A patient must attend for treatment once in four weeks. The medical practitioner notifies the Commissioner of Health of the name and address of the patient when he has failed to attend for six weeks. The Commissioner must conduct, free of charge, bacteriological and other examinations required by any medical practitioner in the treatment of patients. Every medical man receiving any salary from the State must examine and treat any patient suffering from venereal disease free of charge to the patient, but he may recover his fees from the Commissioner, who may be sued for them. Persons under detention may apply to a judge or magistrate to be examined, once in each six months. Power is given to the Commissioner to act on the signed statement of any person in which it is alleged that any person is suffering from venereal disease. The Commissioner may, if he sees fit, require the person mentioned in the information to consult a medical man and to obtain a certificate as to the presence or absence of venereal disease. No person is allowed to publish or distribute any statement to promote the sale of any drug or appliance for the alleviation or cure of venereal diseases, except such statement be made in good faith to promote the advancement of medical knowledge. The Western Australian Act does not contain the provision as to the liability of the owner or occupier of a house to which a female person suffering from venereal disease resorts for the purpose of prostitution.

Naval and Military.

There are no names of any medical men in either the 283rd or the 284th list of casualties which were issued on March 29 and March 30, 1917, respectively. In the former list appears the name of Captain J. A. Pollock among those ill in hospital. Captain Pollock is Professor of Physics at the University of Sydney.

¹ For the text of this Act, see *The Medical Journal of Australia*, February 12, 1916, p. 148.

It is with great regret that we learn of the death of Captain M. R. Hughes, which took place on March 20, 1917. His name is included in the 285th list of casualties, which was issued on April 5, 1917, under the heading "Killed in Action."

In the 286th casualty list, issued on April 9, 1917, the name of Captain J. Stewart appears among those ill in hospital.

The following announcements have been made in the *Commonwealth of Australia Gazette* of March 29, 1917:—

Permanent Naval Forces of the Commonwealth (Sea-going).

Appointment—

Hugh Alton Chandos Wall, M.B., is appointed Surgeon for temporary service, as from 15th February, 1917, with salary at the rate of Twenty-five shillings (25s.) per diem and rations, and to be paid Equipment Allowance of Twenty-five pounds (£25) on first appointment.

Royal Australian Naval Reserve.

Termination of Appointment

The temporary appointment of Leonard Graeme Muirhead, M.B., as Acting District Naval Medical Officer, Port Adelaide, is terminated on 11th February, 1917. Staff Surgeon Edward Walter Morris, R.A.N.R., having resumed duty on 12th February, 1917.

Army Medical Corps.

To be Captains—

Honorary Captain G. O. Robertson, Australian Army Medical Corps Reserve. Dated 7th March, 1917.

Andrew Buchanan Steele and Hugh Hunter Jamieson. Dated 26th February, 1917.

Termination of Appointments —

The appointments of the undermentioned officers are terminated from dates stated opposite names:—

Major C. A. Edwards. Dated 10th February, 1917.

Captain J. E. F. McDonald. Dated 7th March, 1917.

Withdrawal of Appointment—

The appointment of the undermentioned officer is withdrawn from date as stated against his name:—

Major H. Priestley. Dated 1st August, 1916.

4th Military District.

Australian Army Medical Corps—

Honorary Captain H. M. Jay to be transferred from Australian Army Medical Corps Reserve, and to be Registrar, No. 7 Australian General Hospital, with temporary rank and pay of Major, at rate prescribed by Financial and Allowance Regulation 340, whilst holding such appointment. Dated 1st February, 1917.

The appointment of Captain (temporary Major) G. M. Hains as Registrar, No. 7 Australian General Hospital, is terminated. Dated 31st January, 1917.

2nd Military District.

Australian Army Medical Corps Reserve—

John Goodwin Watson Hill, Mark Cowley Lidwill, and Harington Thomas Cuthbert MacCulloch, to be Honorary Captains. Dated 6th March, 1917.

Michael Stanislaus Vasech to be Honorary Captain. Dated 8th March, 1917.

Andrew Joseph O'Flanagan to be Honorary Captain. Dated 12th March, 1917.

3rd Military District.

Australian Army Medical Corps Reserve—

Olaf François de Lacy to be Honorary Captain. Dated 15th March, 1917.

4th Military District.

Australian Army Medical Corps Reserve—

Matthew Edward Goode to be Honorary Captain. Dated 23rd February, 1917.

Melville Birks to be Honorary Captain. Dated 12th March, 1917.

5th Military District.

Australian Army Medical Corps Reserve—

John Kenny to be Honorary Captain. Dated 21st January, 1915. (This cancels the notification respecting the date of appointment of this officer which

appeared in Executive Minute No. 231/1915, promulgated in *Commonwealth of Australia Gazette*, No. 29, of 10th April, 1915.)

David Duncan Paton to be Honorary Captain. Dated 1st July, 1915. (This cancels the notification respecting the date of appointment of this officer which appeared in Executive Minute No. 694/1916, promulgated in *Commonwealth of Australia Gazette*, No. 100, 10th August, 1916.)

The following announcements have been published in the *Commonwealth of Australia Gazette* of April 5, 1917:—

Divisional Staffs.

Anzac Mounted Division.
Lieutenant-Colonel (temporary Colonel) R. M. Downes to be Assistant Director Medical Services, Anzac Mounted Divisional Base and Australian Headquarters, Egypt, in addition to his duties as Assistant Director Medical Services, Anzac Mounted Division. Dated 6th September, 1916.

4th Australian Division.

Major L. W. Jeffries, D.S.O., from 12th Field Ambulance, to be Deputy Assistant Director Medical Services. Dated 16th December, 1916.

5th Australian Division.

Major R. S. McGregor, from 4th Field Ambulance, to be Deputy Assistant Director Medical Services. Dated 16th December, 1916.

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the fortnight ending March 31, 1917:—

	Metropolitan District.		Hunter River District.		Rest of State.		Total.
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.	Cs. Dths.
Enteric Fever ..	18	0	3	0	49	4	70 4
Scarlatina ..	59	1	2	0	85	0	146 1
Diphtheria ..	133	4	8	0	247	11	388 15
Cerebro-spinal Meningitis ..	3	2	1	0	23	15	27 17
Poliomyelitis ..	0	0	0	0	1	0	1 0
Malaria ..	1	0	0	0	0	0	1 0
Pulmonary Tuberculosis*	55	21	3	1	4	3	62 25

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

We are informed by the Department of Public Health, New South Wales, that a case of variola has occurred at Walgett. Two further cases have occurred at Coonamble.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the fortnight ending April 1, 1917:—

	Metropolitan.		Rest of State.		Total.
	Cs.	Dths.	Cs.	Dths.	Cs. Dths.
Diphtheria ..	109	2	95	1	205 3
Scarlatina ..	31	1	26	0	57 1
Enteric Fever ..	8	2	26	3	34 5
Pulmonary Tuberculosis	36	9	21	5	57 14
Cerebro-spinal Meningitis ..	3	—	2	—	5 —
Poliomyelitis ..	0	—	1	—	1 —

THE HEALTH OF QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the fortnight ending March 31, 1917:—

Disease.	No. of Cases.	
Diphtheria ..	101	
Scarlatina ..	44	
Enteric Fever ..	40	
Pulmonary Tuberculosis ..	15	
Cerebro-spinal Meningitis ..	10	
Poliomyelitis ..	2	
Malaria ..	2	
Erysipelas ..	5	
Ankylostomiasis ..	12	

THE HEALTH OF SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, South Australia, during the week ending March 17, 1917:—

	Adelaide.		Rest of State.		Totals.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria ..	5	1	27	0	32	1
Enteric Fever ..	1	1	17	1	18	2
Pulmonary Tuberculosis	2	2	15	11	17	13
Pertussis ..	0	0	29	2	29	2
Scarlatina ..	2	0	8	1	10	1
Cerebro-spinal Meningitis	0	0	4	0	4	0
Morbili ..	0	1	0	0	0	1
Erysipelas ..	0	0	1	0	1	0

INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the four weeks ending March 24, 1917:—

	Metropolitan.	Rest of State.	Totals.
	Cases.	Cases.	Cases.
Enteric Fever ..	20	15	34
Diphtheria ..	32	17	49
Scarlatina ..	5	6	11
Bilharzia Hæmatobia ..	1	0	1
Pulmonary Tuberculosis ..	22	15	37
Erysipelas ..	1	1	2
Ophthalmia ..	1	0	1
Cerebro-spinal Meningitis ..	1	2	3
Pyæmia ..	1	0	1
Malaria ..	1	0	1
Septicæmia ..	2	1	3

THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the fortnight ending March 31, 1917:—

Disease.	Hobart.	Launceston.	Country.	Whole State.
	Cases.	Cases.	Cases.	Cases.
Diphtheria ..	14	3	21	38
Scarlatina ..	2	0	1	3
Pulmonary Tuberculosis	5	0	2	7
Enteric Fever ..	2	1	9	12
Ophthalmia Neonatorum	0	1	1	2

The Minister of Public Health of New South Wales has appealed to the members of the medical profession, through the medium of the daily press, to come to his assistance for "home medical service." He suggests that practitioners who have retired from practice may be willing to undertake duties during the present shortage of doctors in the State. We regret that the Minister should have found it advisable to approach the medical profession through the public press rather than to appeal to them through the medium of their own journal.

Hearty congratulations have been extended to Dr. Cecil Purser on his election to the position of Vice-Chancellor of the University of Sydney. The election took place on April 3, 1917. We understand that Dr. Purser is the first Sydney graduate to hold this important position.

Abstracts from Current Medical Literature.

OPHTHALMOLOGY.

(112) Convergent Squint.

Harrison Butler deals in a frank and honest manner with the results of squint operations (*Ophthalmoscope*, December, 1916). He suggests that the chief object of the operation is a good cosmetic result. If fusion develops, so much the better, but the patient is not concerned with that. The author confesses to failure with fusion training, and there are certain anomalies which raise doubts whether all the theories of binocular vision are correct. He prefers to operate with local anaesthesia at the age of 7 or 8 years. In 76 operations there were 39 successes, 28 partial successes, and 9 failures. Three of the failures were converted into successes at a second operation. In all cases but one, the operation was tenotomy of the central tendon of the median rectus and Worth's advancement of the lateral rectus. His later operations were reinforced by an "anchor suture." A fine catgut suture is inserted close to the external canthus through the conjunctiva, Tenon's capsule and muscle, and threaded through the tag of tendon left attached to the insertion. It is returned back through the tag, muscle, Tenon's capsule and conjunctiva. The tenotomy can be performed by seizing the muscle through the conjunctiva and capsule with forceps, and cutting the whole mass of tissue with scissors. After ten days, when the sutures are removed, the result may be disappointing, but it may improve in a few weeks as the wounds cicatrize. It is futile to suppose that the operation can be "dosed" to a few degrees. The common form of failure is due to the suture cutting out of the limbus on the third day. Simple advancement without tenotomy has not been successful.

(113) Progressive Macular Degeneration.

Marcus Feingold (*Archives of Ophthalmology*, November, 1916) placed on record three cases of progressive macular degeneration in patients who were the offsprings of Russian Jews. In Mrs. D., aged 38 years, the outer macular area formed a horizontal rhomboid; its colour was a greyish-yellow, due to pigment absorption. The central area was also rhomboidal, and was purplish-red in colour. There was a focus of chorio-retinitis at the nasal side of the disc. The vision was good. The second patient, Mrs. B., was 36 years of age. There was a cherry-red spot at each macula. On the temporal side of each macular area was seen a group of yellowish-white spots, colloid bodies, lying behind the retinal vessels.

The vision was good. The third patient, Herbert P., was 26 years of age. He first noticed his distant vision failing at the age of 22 years. The vision was $\frac{7}{10}$. The outer macular area was horizontally oval and of a greyish-yellow, marbled appearance; the central area was comma-like and purplish-red. The patient was colour blind. The striking symmetrical arrangement at once suggests the idea of congenital and hereditary factor. There were other marks of ocular inherited stigmata among other members of the family, such as colour blindness in all the brothers and posterior cataract in the mother. For the first time the condition is described in a Jewish family. The onset is generally placed at the age of puberty. The central red spot may be considered an early stage, and is explained by slight thinning of the retina. The greyish-yellow area around the central red spot is due to absorption of pigment cells. The aetiology is obscure.

(114) Tuberculosis of the Retinal Arteries.

Edward Jackson believes that the condition called recurring retinal haemorrhage in young persons may be due to intra-ocular tuberculosis (*Archives of Ophthalmology*, November, 1916). The diagnosis must rest on the ophthalmoscopic picture, and the special reactions. The latter are often negative. Within the last two years the author has seen five cases of retinal tuberculosis. A coloured plate is published, illustrating the appearances seen in one case. This picture is exceptionally favourable for the study of the ophthalmoscopic appearances. Some localized clouding of the vitreous was always seen, and from time to time diffuse clouding from hemorrhage. A striking feature in these cases is the presence of greyish, rounded spots, smaller than the disc, and located in one of the larger vessels. They appear to be exudates involving the vessel wall and adjoining vitreous. One vessel was dilated to four times its normal diameter, and had become tinged a grey colour. This condition disappeared after six months. Some small white spots in the macula were also seen. These were regarded as important signs of the disease. The optic disc had become hidden in a grey, non-vascular haze resembling papilloedema, but not followed by atrophy but by *retinitis proliferans*. The lesions reacted to tuberculin injections.

(115) Tuberculosis of the Choroid.

Sydney Stephens records the histories of three cases to illustrate the diagnostic value of tubercles of the choroid (*Ophthalmoscope*, December, 1916). His first patient was a baby of seven months, who had had a cough for two weeks. He was admitted into hospital with a temperature of 100° F., a pulse-rate of 120, and a respiratory rate of 36. The diagnosis of apical pneumonia was made. On the

following day a large circular tubercles of the choroid were seen in the central region of the left fundus. The patient died on the second day, and at the post-mortem examination a general miliary tuberculosis was discovered. The second case was in a child aged 6 years, who was admitted into hospital with high fever and abdominal pain. As the provisional diagnosis of pneumococcal peritonitis had been made, the abdomen was opened. The peritoneum was found to be studded with small miliary tubercles. Four days later tubercles were found in both choroids. The child died about six weeks later. The third patient, a child of three years, was admitted into hospital for lobar pneumonia. Symptoms indicative of enteric fever were observed a little later. After the child had been in the hospital for a fortnight, two tubercles were discovered in the left fundus. The child died of miliary tuberculosis. The eyes, examined after death, were seen to contain tubercles of typical structure; there were tubercle bacilli in the giant-cell systems. These cases were met with within the course of two months. The use of euphthalmalmin and of the electric ophthalmoscope is spoken highly of. The author also advocates the employment, if necessary, of chloroform, speculum and fixation forceps.

(116) Diagnosis in Uveitis.

Euphan Maxwell writes a careful article on the diagnosis in uveitis (*Ophthalmoscope*, September and December 1916). She begins with a brief survey of the classification and the diagnostic measures already in use, such as the clinical signs and symptoms, the histological and bacteriological examination of the uveal tissue and aqueous humour, the examination of the blood, urine, faeces and mucus, the various immunity and anaphylactic reactions. The author then describes in more detail the results of a year's experimental work. She attempted to produce an artificial uveitis in a rabbit's eye by an intra-ocular injection of a known bacterium. In due course she examined the aqueous humour for the various specific antibodies. *Bacillus coli*, *staphylococcus aureus*, *bacillus typhosus*, *spirochaeta pallida*, and the tubercle bacillus were employed. Though some of the results obtained were indefinite, the author was able to make certain deductions. The experiments demonstrated that the formation of an amboceptor produced in response to an intra-ocular infection is mainly due to general cellular activity. The examination of the aqueous humour by the fixation of complement method has no practical diagnostic value which is not also possessed by a similar examination of the blood. In cases of intra-ocular inflammation co-existing with some other infection elsewhere, a relative, and in some cases an absolute preponderance, of the amboceptor produced in response to the ocular infection existed in the infected aqueous humour. She considers that the method should receive attention from others.

(117) Optic Nerve Atrophy with Chiasmatal Lesions.

Anyone interested in hypophyseal surgery will find ample food for this study in a series of carefully-described and beautifully-illustrated cases by Clifford Walker and Harvey Cushing (*Archives of Ophthalmology*, September, 1916). The material was derived from eight fatal cases of pituitary tumour cut of a series of some 200 operations. The object of the present investigation was to compare the anatomical findings in the optic nerves and tracts with the ophthalmoscopic picture and fields of vision. It was found that perimetric defects were to be regarded as evidence of physiological block than of anatomical distinction of the nerves, in view of the great degree of recoverability of sight after operation to relieve pressure. Histological examination of the nerves failed to show the expected degree of fibre degeneration unless the process had been of long duration.

LARYNGOLOGY AND OTOTOLOGY.**(118) Clinical Type of Labyrinthitis.**

Wendell C. Phillips (*Journ. Amer. Med. Assoc.*, February 3, 1917) divides internal ear inflammation, from a clinical standpoint, into 'circumscribed and diffuse labyrinthitis. He also notices paralabyrinthitis, a condition of chronic otitis media, with vertiginous attacks, supposedly due to disease attacking, but not eroding, the bony labyrinth. The circumscribed form generally occurs with chronic suppuration of the middle ear. The bony capsule is eroded, but owing to a walling off of the infective process, the endolabyrinthine spaces are not penetrated. There is fairly acute hearing; the rotation and caloric tests are normal, and the fistula test positive. The diffuse form may be secondary to acute or chronic middle ear suppuration, metastatic, or an extension of meningitis. It may be acute, occurring with acute or chronic otitis media, or chronic with sudden onset, rapidly developing deafness, nausea, vomiting and vertigo, but without fever or pulse acceleration, and without intracranial complications. The Vienna school prefers the classification of serous and suppurative labyrinthitis, according as there is retention or destruction of labyrinthine function. There are two classes of acute labyrinthitis complicating acute suppurative otitis media: (1) Those occurring during the first three or four days, generally mild or serious cases, rarely associated with intracranial complications, and early restoration of function. (2) Those occurring six to eight weeks after the commencement of the middle ear suppuration. These are grave cases, frequently lead to meningitis, and have very violent labyrinthine symptoms. The labyrinth may become

filled with granulations, and these may extend into the internal auditory meatus, occluding the labyrinthine artery and occasioning extensive death of the bony labyrinth capsule, with the formation of a sequestrum, and often accompanied by facial paralysis. This is a dangerous and insidious type of labyrinthitis, which may lead to meningitis, cerebellar abscess, or sinus thrombosis. The author holds that in cases of chronic suppurative otitis media with vertigo, and no other labyrinthine symptoms, the radical mastoid operation is indicated. Circumscribed labyrinthitis, with normal rotation and positive caloric and fistula tests, also calls for the radical mastoid operation. In acute diffuse labyrinthitis, complicating acute otitides, a free myringotomy generally suffices, even when hearing is lost and the caloric test is negative; but when the acute middle ear suppuration is of 6 to 10 weeks' duration, a labyrinthine operation is justifiable. The prognosis is not good. Neumann's operation, i.e., the entire removal of the bone including the border of the internal auditory canal, and drainage, of the cerebellar spaces, is the ideal procedure. In diffuse labyrinthitis complicating chronic suppurative otitis media labyrinthectomy is recommended. In every case of destroyed labyrinth, whenever there are signs of intracranial complications, the posterior fossa should be uncovered.

(119) Purulent Labyrinthitis and Cerebellar Lesions.

According to Isidore Friesner (*Journ. Amer. Med. Assoc.*, February 3, 1917) the most important conditions with symptoms similar to labyrinthine disease are cerebellar. These symptoms he groups as either general and due to increased intracranial pressure or inflammatory processes, or focal, which may be evidenced in movement or disturbances in the vestibular apparatus. The general symptoms comprise disturbances of the sensorium, and of respiration, bradycardia, optic-nerve changes, and paralysis of cranial nerves. In labyrinthitis none of these symptoms are present except disturbances in the 8th and occasionally the 7th cranial nerves only. In cerebellar lesions there is headache (90% of all cases of abscess), vomiting, persistent and generally projectile and absence of fever. In the case of abscess the temperature may be subnormal or raised, and there may be emaciation and changes in cerebrospinal fluid. In labyrinthitis there is vomiting with much nausea, daily increasing in intensity. The vocal symptoms or cerebellar lesions include hypermetria, asynergy, adiadosokinesis, tremor, disturbances of speech, atony, catalepsy, hemiparesis, and fixed attitude of head. Cerebellar and labyrinthine lesions both give rise to abnormalities of the voluntary movements of the trunk and limbs. The labyrinthine symptoms depend on impulses from the static labyrinth as well as from the muscles and joints of the neck. Changes in these peripheral impulses

cause alteration in the direction of deviating movements. The relationship between the spontaneous nystagmus and the deviations is constant, and characteristic of labyrinthine lesions. In cerebellar lesions there is no definite relationship between the disturbance of balance and the nystagmus; if the latter be present at all, the direction of the fall will not necessarily be to the side of the slow component. The fallings and deviations of the extremities are central in origin, and the direction is not influenced by changes in the peripheral impulses. The nystagmus frequently lasts much longer than the normal $2\frac{1}{2}$ to 3 minutes. Loss of the reaction movements which occur normally may be decided when the vestibular impulse is artificially aroused. Nystagmus of central origin often cannot be differentiated clinically from that due to labyrinthine disease. In diffuse labyrinthitis the nystagmus is generally to the opposite side, whereas in cerebellar lesions the nystagmus may vary at different times, especially with abscess. In tumours, according to the position of the head, a variation in the direction of the nystagmus may be elicited, and it is commonly observed in the antero-posterior vertical plane. This the author has never observed in labyrinthitis. The nystagmus with diffuse labyrinthitis grows less in intensity from day to day, but that of central origin remains the same or may increase.

(120) Post-Nasal Infections.

In a clinical study of sixty cases of post-nasal infection, unaccompanied, except in three cases, by acute tonsillitis, G. E. Baxter (*Archives of Pediatrics*, October, 1916) found that practically all had some form of complication. Otitis media occurred in 70 per cent. of the cases, and in 80 per cent. of the patients under two years of age. Next in frequency was cervical adenitis, complicating about a third of the cases in children under two years, but being more frequent in older children. Nephritis occurred in six cases (10 per cent.). The occurrence of otitis media, which was probably due to the susceptibility of the third tonsil to infection, was less frequent after the first two years, but other and more serious complications were more frequent. In otitis media cases without drainage through the external auditory canal were found to recover as quickly and completely as those drained by paracentesis or spontaneous rupture, especially during the first two years. Bacteriologically cases usually showed a pure culture of staphylococcus. The author refers to the frequency of reports of cases of acute nephritis following acute tonsillitis, but the lack of mention of the post-nasal space as the original focus of infection. He advises watchfulness in all cases of mild cold in the head and simple earache for signs of acute hæmorrhagic nephritis. In the treatment of post-nasal infections he recommends the use of a nasal douche with gravity pressure.

British Medical Association News.

SCIENTIFIC.

A meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on March 2, 1917, Dr. W. N. Robertson, the President, in the chair.

Dr. Andrew Stewart showed some photographs of a patient on whom *artificial pneumothorax* had been performed.

Dr. Andrew Stewart read a paper on the *early diagnosis of pulmonary tuberculosis from a public health point of view*. The paper is published in full on page 312.

The President thanked Dr Stewart for having read this excellent paper.

Captain Russell congratulated Dr. Stewart on his paper. He questioned whether failure in making a diagnosis on the part of general practitioners was really due to carelessness; the making of a diagnosis was not an easy matter. It would be a good thing to have a clearing station in every city where suspected cases could be examined by an expert like Dr. Stewart. He was surprised to learn that so many children suffered from phthisis. If these children were examined by an expert they might be saved. He was inclined to the opinion that enough stress had not been laid on the presence of anaemia and lassitude in early phthisis. He held that von Pirquet's test, when applied with tuberculin well diluted, was a useful diagnostic test. To his mind the most important thing was early diagnosis at a clearing station or dispensary by an expert. Compulsory notification was not enforced rigidly enough.

Dr. G. Comyn called attention to the experience of every practitioner who had been in practice for a number of years, that several members of a family not infrequently suffered from pulmonary tuberculosis. He was certain that the disease was not hereditary.

Dr. Graham Brown said that Calmette's test was absolutely unjustifiable in the opinion of ophthalmologists. To introduce tuberculin into the conjunctival sac of a patient suffering from any tubercular lesion of the eye was almost criminal.

Dr. Kerr Scott said that he would like to say something in defence of the general practitioner. If he detected crepitations at the apex and suspected tuberculosis, and if he had the sputum examined, the patient always wanted to know the result. If the patient was told that no tubercle bacilli had been found in the sputum, he, the patient, often broke off the treatment, and at times consulted another practitioner later on. He could not see how the general practitioner could be accused of failing to recognize early cases, if the patients did not remain under his care.

Dr. T. H. R. Mathewson stated that he had recently diagnosed phthisis in a man, and the case was notified to the Health authorities. The patient had been living at a boarding-house. The officials from the Department of Public Health visited the house, and as a result the man was turned out. After some difficulty the man was admitted to the Diamantina Hospital, and was sent to Dalby. Dr. Mathewson considered that there ought to be a hospital in Brisbane, where patients in this condition could be sent.

Dr. E. J. S. Spark also wished to defend the general practitioner. He often missed a case, it was true, but if he told a patient that he had phthisis, in many cases he would not see that patient again. He thought that practitioners often suspected tuberculosis, although they did not recognize the physical signs. He was of opinion that a great deal of good was done in the treatment of tuberculosis at dispensaries, and also in the examination of contacts. The speaker said that a practitioner must be careful what he said to the patient or to the parents of a patient, when he suspected him to be suffering from phthisis.

Dr. Herbert Stewart considered it incumbent on the practitioner to tell his patient straight out that he thought he had tuberculosis. It was very difficult to make provision for all the patients who were dying of the disease. He was sure that patients often improved just as well at home as they did at a sanatorium. If the house were well ventilated and the patient were well fed, he might do better than at the sanatorium, especially if the financial strain and the separation from his family worried him. Pulmonary tuber-

culosis in children was very rare. The early signs of tuberculosis were difficult to detect.

Dr. W. S. S. Page agreed with Dr. Herbert Stewart that people who were well off could be looked after at home. But among the poorer class sanatorium or hospital treatment was necessary to protect the other members of the family.

Dr. W. F. Taylor said that they had not the means of grappling with tuberculosis. He thought that very little had come of notification. Very little had been done after the cases had been notified. He questioned whether the spread of consumption had been controlled by the prevailing methods of dealing with the disease. He held that the matter ought to be taken in hand by a competent health authority and looked after, so that contagion would be prevented.

Dr. J. L. Sleewood mentioned the case of a girl in whose sputum tubercle bacilli had been discovered. He had advised treatment in hospital, but the mother had refused to allow the girl to go into a hospital. Consequently the other members of the family were exposed to infection.

Dr. W. N. Robertson expressed pleasure that so many members had joined in the discussion. In his own practice he often saw patients with suspicious signs in their larynges suggesting early phthisis. It was difficult to be sure of the normal breath sound at the right apex, and also at the bases of the lungs, and to detect early pathological changes. A large number of persons with early tuberculosis got better without any treatment. The disease was not recognized in these people during life. He had seen very little pulmonary tuberculosis in children in Australia.

In his reply, Dr. Andrew Stewart said that he was very pleased to have heard the discussion. The Government meant to start a tuberculosis dispensary, but owing to lack of funds, they had been forced to relinquish the idea. He agreed with Dr. Graham Brown in regard to the Calmette test, and said that in cases in which this test had been applied and a positive reaction obtained, a reaction in the eye occurred each time an injection of tuberculin was given. He agreed with Dr. Kerr Scott that notification was the last rung in the ladder, and that the sanatorium was the second last. He was in accord with all the remarks which had been passed. A mistake which the Society for the Prevention of Tuberculosis had made was that it had frightened everybody.

MEDICO-POLITICAL.

A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on March 28, 1917, Professor R. J. A. Berry, the President, in the chair.

It was announced that a communication had been received from the Secretary of the 'Friendly Societies' Association, intimating that he hoped to be able to arrange a conference between the representatives of the Victorian Branch of the British Medical Association and the representatives of the 'Friendly Societies' Association within a week. It was resolved to elect Dr. J. R. Davis, of Port Melbourne, a member of the War Organization Committee. It was held that Dr. Davis's experience in lodge matters in Newcastle, New South Wales, would prove invaluable to the Council.

It was resolved that steps be taken to bring about a meeting of representatives of the Pharmaceutical Society with the Council, for the purpose of discussing the formulation of regulations of practice to be observed by medical practitioners and by pharmacists.

A communication from the New South Wales Branch, dealing with the subject of equality of obligation of medical practitioners and the proposal to seek powers to enrol all medical practitioners as persons liable for enlistment in the Australian Army Medical Corps Reserve was read. The Council of the New South Wales Branch invited the Council to consider this proposal, with the view to its adoption. The New South Wales Branch proposed further to submit the proposal to the Federal Committee. After a prolonged discussion, it was resolved:—

That this Council cannot support the proposals of the New South Wales Branch, suggesting compulsory service of medical men.

This Council is proud of the fact that it has already a large proportion of the members of the Branch on the Australian Army Medical Corps Reserve, and urges the Federal Committee to suggest to the Council of each Branch that it take steps to secure the enrolment of the whole of its members on the Australian Army Medical Corps.

Further, it is of opinion that if this be done, a Committee officially recognized by the Defence Department should be appointed in each State to assist that Department by undertaking the organization of the profession on these lines.

It having been ascertained that the previous appointment of members as members of the Victorian Branch on the Federal Committee was not in order, it was resolved that the appointments be re-made. General R. H. Fetherston and Mr. G. A. Syme were elected the two representatives of the Branch on the Federal Committee.

The attention of the Council was directed to a notice which had appeared in the daily newspapers that the Government grant had been withheld from the Hamilton Hospital at the instigation of the Inspector of Charities, on the ground that persons able to pay for treatment were being attended to at this institution. It was stated that the Premier, after having received a deputation from the Hospital and listening to their complaints, had expressed himself as being in favour of restoring the grant. A letter had been sent to the Private Secretary of the Premier, pointing out that the Victorian Branch of the British Medical Association had consistently opposed the principle of patients who were able to pay for medical attention to private practitioners, making use of hospitals maintained by a Government grant and by public charity. The Council considered that this practice was a gross abuse of public charity and an imposition upon the services of medical practitioners who gave their services gratuitously. The Council expressed the hope that the Premier would not restore the Government grant to the Hamilton Hospital, since this grant had been justly withheld, until the Committee of the Hospital had conformed to the conditions laid down by the Inspector of Charities.

The following have been nominated for election as members of the New South Wales Branch:—

Harriette Martha Exton, M.B., Ch.M., Univ. Syd., 1917, Royal Alexandra Hospital for Children, Camperdown.

Ettie Lyons, M.B., Univ. Syd., 1908, 109 Ocean Street, Woollahra.

Alfred Roy Hudson, M.B., Univ. Syd., 1917, Balmain Hospital.

Omission.

We regret to note that the name of Dr. Fourness Barrington was omitted from the list of newly elected members of the New South Wales Council of the New South Wales Branch (see page 304).

VENEREAL DISEASES ACT.

An Act Relating to Venereal Diseases and to Amend Part V. of the Police Offences Act, 1915.

[28th December, 1916.]

Be it enacted by the King's Most Excellent Majesty by and with the advice and consent of the Legislative Council and the Legislative Assembly of Victoria in this present Parliament assembled and by the authority of the same as follows (that is to say):—

1. This Act may be cited as the *Venereal Diseases Act 1916* and shall (save as to Part II. hereof) be read and construed as one with the *Health Act 1915* and any Act amending the same which Acts and this Act may be cited together as the *Health Acts*.

Part I.—Venereal Diseases.

2. (1) In this Part of this Act if not inconsistent with the context or subject-matter—

(a) "Child" means a person under the age of sixteen years;

"Managers" includes board committee or other body managing any hospital;

"Medical inspector" means the medical inspector of the Board of Public Health;

"Prescribed" means prescribed by this Part of this Act or by regulations under this Part of this Act;

"Venereal disease" means gonorrhœa, gonorrhœal ophthalmia, syphilis, soft chancre, venereal warts or venereal granuloma.

(b) Words importing the masculine gender shall be deemed and taken to include females.

(c) Any references to a medical practitioner shall in any case where a person attends for treatment at a hospital or other prescribed place and with respect to notices required by this Part of this Act in such a case mean the medical officer of the hospital or other prescribed place for the time being in charge of cases of venereal disease thereat.

(2) This Part of this Act shall be read and construed as in aid of and not in derogation of the provisions of the *Infant Life Protection Act 1915*.

3. (1) The provisions of division one of Part VI. of the *Health Act 1915* as amended by any Act shall not apply to venereal disease.

(2) Division two of Part VI. of the *Health Act 1915* is hereby repealed.

4. The Governor in Council may by proclamation published in the *Government Gazette* appoint any hospital maintained by or receiving aid from the State or any ward of any such hospital as a place in which persons may under this Part of this Act be detained for treatment.

5. (1) No person other than a medical practitioner or a person acting under the direct instructions of a medical practitioner shall attend upon or prescribe for or supply any drug or medicine to any person suffering from any venereal disease for the purpose of curing alleviating or treating such disease.

(2) Any person guilty of a contravention of this section shall be liable to a penalty of not more than Fifty pounds or to imprisonment with or without hard labour for a term of not more than six months.

(3) This section shall not apply to a registered pharmaceutical chemist who dispenses to the patient of a medical practitioner the prescription of such practitioner if such prescription is dated and bears the address and usual signature (including the surname) of such practitioner or who sells or supplies any drug or medicine (except such drugs or medicines as are specified by regulations under this Part of this Act) in the ordinary course of his business, provided that such drug or medicine is not prescribed by such chemist for any person suffering from any venereal disease for the purpose of curing alleviating or treating such disease.

6. (1) Every person suffering from any venereal disease or suspecting that he is so suffering shall forthwith on becoming aware of his condition consult a medical practitioner thereon furnish his correct name and address to such medical practitioner and place himself under treatment by such medical practitioner or shall attend at some hospital or other place prescribed for the purpose and place himself under treatment thereat.

(2) Any person guilty of a contravention of this section shall be liable to a penalty of not more than Twenty pounds.

7. (1) Every person suffering from any venereal disease who has consulted and placed himself under treatment by a medical practitioner or has attended and placed himself under treatment at a hospital or other prescribed place shall (until he has received a certificate of cure or of being free from venereal disease) personally attend or cause himself to be attended by a medical practitioner or personally attend at a hospital or other prescribed place for the purpose of treatment and advice at least once in every such period as is prescribed and shall follow the advice given by such medical practitioner or by a medical practitioner at such hospital or place.

Any person guilty of a contravention of this sub-section shall be liable to a penalty of not more than Twenty pounds.

(2) If any such person by reason of change of residence or otherwise desires to change his medical adviser, or if the medical practitioner attending such person dies or for any reason is unable or unwilling to attend him further, such person shall forthwith consult and place himself under the treatment of another medical practitioner and inform his new adviser of the name and last known address of his last previous adviser. The medical practitioner so informed shall forthwith send a notice in the prescribed form of the change made by the patient to such previous adviser if such adviser is living and in Victoria.

Any such person or medical practitioner who is guilty of a contravention of this sub-section shall be liable to a penalty of not more than Five Pounds.

8. (1) If a medical practitioner becomes aware that any person consulting or attended or treated by him is suffering from any venereal disease the medical practitioner shall in the prescribed form and within the prescribed time give notice thereof to the medical inspector.

(2) Such notice shall not disclose the name and address of the patient.

(3) Any medical practitioner guilty of a contravention of this section shall be liable for a first offence to a penalty of not more than Twenty pounds and for a second and every subsequent offence to a penalty of not less than Twenty pounds or more than One hundred pounds.

9. (1) If any patient who has been attended or treated by a medical practitioner for any venereal disease fails to consult or attend such medical practitioner at least once during every such period as is prescribed and the medical practitioner has not before the expiration of ten days after the said period received from another medical practitioner a notice that the patient has changed his medical adviser such first-mentioned medical practitioner shall send to the medical inspector in a sealed envelope marked "Confidential" in the prescribed form a notice of the facts including the name and address of the patient.

(2) Any medical practitioner whose duty it is to do so who does not send the said notice to the medical inspector shall be liable for a first offence to a penalty of not more than Twenty pounds and for a second or any subsequent offence to a penalty of not less than Twenty pounds or more than One hundred pounds.

10. (1) Every medical practitioner who attends treats or advises any patient for or in respect of any venereal disease from which the patient is suffering shall (except in the case of a child)—

(a) by written notice in the prescribed form delivered to the patient—

(i) direct such patient's attention to the infectious character of the disease and to the legal consequences of infecting others; and

(ii) warn the patient against contracting any marriage until certified as cured; and

(b) give such patient such printed information relating to the disease and the duties of patients as is prescribed.

(2) In the case of a child suffering from any venereal disease every medical practitioner who attends treats or gives advice with respect to the child shall give to the parent or guardian or other person in charge of the child such directions and printed information as are prescribed.

(3) Any medical practitioner guilty of a contravention of this section shall be liable to a penalty of not more than Five pounds.

11. (1) Subject to this Part of this Act when any patient as aforesaid becomes cured of or free from venereal disease or has ceased to be liable to convey infection any medical practitioner shall on being satisfied of the fact and subject to the regulations give such patient at his request a certificate in the prescribed form that such patient is cured or is free from venereal disease or is no longer liable to convey infection (as the case may be).

(2) Any medical practitioner who gives to any person a certificate that such person is cured or is free from venereal disease or is no longer liable to convey the in-

fection of any such disease knowing the said certificate to be false in any material particular shall be liable to a penalty of not more than Fifty pounds.

12. (1) Any parent guardian or other person in charge of any child suffering from any venereal disease shall cause such child to be treated by a medical practitioner.

(2) When any child is or becomes liable under this Part of this Act to do or submit to any act matter or thing any parent or guardian or other person in charge of such child who knows that such child is so liable shall exercise his authority to compel or induce such child to do or submit to such act matter or thing as aforesaid.

(3) Any parent or guardian or other person in charge of any such child who knows that such child has failed to comply with any provision of this Part of this Act applicable to such child shall report the fact together with such particulars as are prescribed to the medical inspector.

(4) Any parent or guardian or other such person guilty of a contravention of this section shall be liable to a penalty of not more than Ten pounds.

13. (1) Whenever the medical inspector is satisfied by the certificate of a medical practitioner or by statutory declaration that there is reasonable ground to believe that any person is suffering from venereal disease and is not under treatment by any medical practitioner he may issue an order in writing requiring such person to place himself forthwith under the care of a medical practitioner.

(2) If such person does not place himself under the care of a medical practitioner a police magistrate on the complaint of the medical inspector or of a medical practitioner authorized in writing either generally or in any particular case for the purpose by the medical inspector may by warrant under his hand in the prescribed form and directed to prescribed persons order the person to be apprehended and to be detained for any prescribed period not exceeding four weeks in any prescribed place for any clinical chemical bacteriological or other examination or investigation necessary to ascertain whether such person is suffering from venereal disease, and it shall be lawful to make any such examination or investigation; and such warrant shall be a sufficient authority to all persons for the arrest and detention of such person in pursuance of the warrant and subject to the provisions of this Part of this Act.

(3) If the result of any such examination or investigation discloses that such person is suffering from any venereal disease and the medical inspector after due inquiry into all the circumstances is of the opinion that further detention is necessary in the interests of such person and of the public welfare and so reports to the Minister then on the recommendation of the Minister the Governor in Council from time to time may order that such person shall be detained under such conditions and in a prescribed or proclaimed place and for such time and be subject to such examination and treatment as are necessary to insure that such person is cured or is free from venereal disease or has ceased to be liable to convey infection; and the Governor in Council may extend or vary any such Order or at any time terminate its operation and thereafter if found necessary renew such Order. And every such Order shall be sufficient authority to all persons for the arrest and the removal or detention of such person in pursuance of the Order until his release under the provisions of this section and subject to the provisions of this Part of this Act.

(4) Any person undergoing detention under this section may from time to time apply in writing in the prescribed form to a Judge of the Supreme Court or Judge of County Courts or police magistrate to be examined by two medical practitioners, and thereupon such judge or magistrate shall by order direct any two or more medical practitioners named in the order (one of whom shall be nominated by the patient or some person on his behalf) to examine such person accordingly and report the result of the examination to the judge or magistrate; and every officer or person in whose custody the person is shall permit the examination.

If after consideration of such report the judge or police magistrate is of opinion that the person is cured or is free from venereal disease or has ceased to be liable to

convey infection the judge or magistrate shall order the release of such person from detention and he shall be released accordingly.

No such application shall be made by any person so detained within three months after a like prior application has been made by such person.

(5) Any person undergoing detention under this section who proves to the satisfaction of the Minister that he can obtain and is prepared to undergo suitable treatment may be released on the order of the Minister subject to such conditions as the Minister imposes.

(6) Any person undergoing detention under this section shall once at least in every period of three months beginning with the date of his arrest be examined by two medical practitioners appointed by the Minister either generally or in any particular case for the purpose in order to ascertain whether such person is cured or is free from venereal disease, or has ceased to be liable to convey infection and such medical practitioners shall report to the Minister accordingly.

If the Minister is satisfied that such person is cured or is free from venereal disease or has ceased to be liable to convey infection the Minister shall order the release of such person from detention and he shall be released accordingly.

Where the person undergoing detention has been examined by order of a judge or police magistrate under this section an examination under this sub-section shall not be necessary until a period of three months has elapsed after the first-mentioned examination.

(7) No person shall be detained under this section after he is cured or is free from venereal disease or has ceased to be liable to convey infection.

(8) No certificate of any medical practitioner given for the purposes of this or the next succeeding section *bonâ fide* and without negligence that any person (including any prisoner) is suffering from venereal disease shall be admissible in evidence in any proceedings civil or criminal against such medical practitioner or be made the ground of any prosecution action or suit against him.

(9) Any person who—

- (a) detains any person undergoing detention under this section except as provided under this Part of this Act; or
- (b) obstructs the carrying into effect of any warrant or order under this section; or
- (c) refuses to do or submit to anything which such person is by this section or any such warrant or order required to do or submit to; or
- (d) while undergoing detention under this section leaves except as prescribed any prescribed or proclaimed place before being lawfully discharged,

shall be liable to a penalty not exceeding Twenty pounds.

14. (1) Where a medical practitioner duly appointed either generally or in any particular case for the purpose certifies in writing to the Minister that any prisoner in any gaol is suffering from any venereal disease such prisoner may be brought before a police magistrate and on proof that such prisoner is so suffering the police magistrate may order that such prisoner be detained under such conditions and in a prescribed or proclaimed place and for such time and be subject to such examination and treatment as are necessary to insure that he is cured or is free from venereal disease or is no longer liable to convey infection.

(2) Such an order shall be sufficient authority to the governor of the gaol to remove such prisoner to the prescribed or proclaimed place named in the order and for his detention therein in pursuance of the order and subject to the provisions of this section.

(3) During any period of detention under this section such prisoner shall be deemed to be in legal custody and the period of detention shall run concurrently with but may exceed the term of imprisonment to which such prisoner has been sentenced.

(4) The provisions of sub-section (4) of the last preceding section shall extend and apply to prisoners undergoing detention under this section.

(5) If the medical inspector is satisfied that any prisoner undergoing detention under this section is cured or is free

from venereal disease or is no longer liable to convey infection he shall so report to the Minister and thereupon the Minister shall order that such prisoner be discharged from such detention and such prisoner unless his sentence has sooner expired shall be remitted to his former custody to serve the remainder of his sentence.

(6) Notwithstanding anything in any Act or any law to the contrary it shall be lawful for any medical practitioner or practitioners duly appointed by the Minister either generally or in any particular case for the purpose to examine any prisoner in any gaol for the purpose of ascertaining whether such prisoner is suffering from venereal disease and to make such clinical chemical bacteriological and other examinations and investigations as are necessary or expedient for the purpose.

(7) The provisions of this section with respect to prisoners shall extend and apply to persons detained in reformatory prisons and to persons committed to reformatory schools, and shall with such alterations modifications and substitutions as are necessary be read and construed accordingly: Provided that for the purposes of this sub-section—

- (a) upon the discharge of any such person from detention under this section such person shall be returned to the reformatory prison or reformatory school from which he was removed; and
- (b) any reference in this section to the governor of a gaol shall be read and construed as a reference to the person in charge of a reformatory prison or the superintendent matron or manager of a reformatory school (as the case may be).

15. (1) Any matter to be heard by a judge or police magistrate under either of the two last preceding sections shall be heard and decided in chambers and in private and no person other than the judge or magistrate the party concerned the medical inspector and such officers witnesses or persons as the judge or magistrate may require or at the request of the party concerned may permit to be present shall have access to or be permitted to be present in any room where the matter is being heard.

(2) Every person who acts or assists in the administration of the said sections and every person present in any room where any matter under the said sections is being heard shall preserve and aid in preserving secrecy with regard to all matters and things which come to his knowledge while so acting or assisting or present and shall not communicate any such matter or thing to any other person except in the performance of his duties under this Part of this Act or in answer to some question which he is legally bound to answer.

Any person guilty of a contravention of this sub-section shall be liable to a penalty of not more than Fifty pounds.

16. If any person to be examined under this Part of this Act is a female then, if so desired by the person to be examined the examination if by one medical practitioner shall be made by a medical practitioner who is a woman and if by more than one medical practitioner all of such medical practitioners shall be women, provided that a woman practitioner or women practitioners (as the case may be) are available within a radius of twenty miles and are willing to act.

17. The fact that a person who has been suffering from any venereal disease has ceased to be liable to convey infection but has not been cured shall not exonerate such person from complying with the provisions of this Part of this Act with respect to treatment or any medical practitioner from complying with the requirements of this Part of this Act with respect to notices.

18. (1) No person shall knowingly infect any other person with a venereal disease or knowingly do or permit or suffer any act likely to lead to the infection of any other person with such a disease.

(2) Any person guilty of a contravention of this section shall be liable to a penalty of not more than One hundred pounds or to imprisonment with or without hard labour for a term of not more than twelve months or to both such penalty and imprisonment.

19. Any person being the owner or occupier of any house room or place in which a female suffering from venereal disease resides for the purpose of prostitution or to which

she resorts for such purpose shall unless he can prove that he did not know that such female prostituted herself while in a state of disease be guilty of an offence under this Act and shall be liable to a penalty of not more than Twenty pounds or at the discretion of the court to imprisonment with or without hard labour for a term of not more than six months: Provided that no conviction under this section shall exempt the offender from any penal or other consequences to which he or she may be liable for keeping or being concerned in keeping a bawdy-house or disorderly house or for the nuisance thereby occasioned.

20. (1) The managers of any hospital receiving aid from the State shall make effective provision as prescribed for the reception accommodation examination and treatment free of charge of such numbers of persons or such classes of persons suffering from venereal disease as are prescribed.

(2) In case of default the Treasurer of Victoria may withhold the whole or any portion of any subsidy which would be payable from the Consolidated Revenue in respect of such hospital during the current or the next financial year.

21. The Minister may—

- (a) establish hospitals or places for the reception and treatment of persons suffering from venereal disease;
- (b) arrange for the examination or treatment by medical practitioners of persons suffering from venereal disease and for the remuneration of such practitioners under any such arrangement;
- (c) arrange for chemical bacteriological and other examinations and investigations free of charge to the patient for the purpose of ascertaining whether a person is suffering from or is cured of any venereal disease or whether he has ceased to be liable to convey infection and for the remuneration payable under any such arrangement;
- (d) arrange for the supply of drugs medicines and appliances for the treatment alleviation and cure of venereal diseases in the cases of persons unable through poverty or otherwise to pay for such drugs medicines or appliances; and
- (e) provide for the preparation and distribution of information relating to venereal diseases.

22. Any person authorized either generally or in any particular case by the Minister may prosecute for any offence under this Part of this Act or any regulation thereunder.

23. (1) The Governor in Council may make regulations for or with respect to—

- (a) the forms and particulars to be contained in notices returns certificates orders and warrants under this Part of this Act;
- (b) the persons or classes of persons who may apprehend any person against whom a warrant or order of apprehension under this Part of this Act has been issued;
- (c) the conditions and circumstances under which a certificate of cure of or of freedom from venereal disease or of having ceased to be liable to convey infection may be issued and the maximum fee chargeable for any such certificate;
- (d) the numbers of persons or the classes of persons who shall be eligible to receive free treatment for venereal diseases at a hospital maintained by or receiving aid from the State;
- (e) the management of any hospital or place provided by the Minister for the reception accommodation examination or treatment of persons pursuant to this Part of this Act.
- (f) prescribing what medical officers of hospitals or other prescribed places shall have charge of cases of venereal disease treated thereat and to or by whom notices required by this Part of this Act shall be given;
- (g) prescribing the periods during which according to the stages or phases of the disease persons suffering from any venereal disease are to attend or cause themselves to be attended by medical practitioners for the purpose of treatment and advice;

(h) the fees payable to medical practitioners for notices given to the medical inspector pursuant to this Part of this Act;

(i) hospitals or places where persons suffering from any venereal disease may be detained for treatment;

(j) returns to be made by medical practitioners with respect to the number of cases of venereal disease attended or treated by them and the number of such cases cured;

(k) prescribing the preventive measures against the spread of infection to be adopted by persons suffering from any venereal disease and by persons attending or having the care or charge of such persons;

(l) penalties not exceeding Twenty pounds for any breach of any regulation made under this Part of this Act; and

(m) generally, all matters necessary or convenient to be prescribed for carrying out the provisions of this Part of this Act.

(2) All such regulations when made by the Governor in Council shall be published in the *Government Gazette* and when so published shall have the force of law and shall be judicially noticed and shall be laid before both Houses of Parliament within fourteen days after the same shall have been made if Parliament be then sitting and if not then within ten days after the next meeting of Parliament, and a copy of any proposed regulations shall be posted to each Member of Parliament at least fourteen days before such regulations are approved by the Governor in Council.

Part II.—Obscene and Indecent Publications.

24. This Part of this Act shall be read and construed as one with Part V. of the *Police Offences Act 1915*.

25. (1) Part V. of the *Police Offences Act 1915* is hereby amended as follows:—

(a) In section one hundred and seventy-three of the said Act there shall be inserted after the words "Any person" where they first occur the following words:—"who exhibits in any picture theatre or place of public resort any film or cinematograph display which is of an indecent or obscene nature and any person" and for the words "Forty shillings" there shall be substituted the words "Five pounds" and for the words "one month" there shall be substituted the words "three months."

(b) In section one hundred and seventy-eight of the said Act for the words "Ten pounds" (wherever occurring) there shall be substituted the words "Twenty pounds" and for the words "one month" there shall be substituted the words "three months" and for the words "Fifty pounds" there shall be substituted the words "One hundred pounds" and for the words "six months" there shall be substituted the words "twelve months."

(c) For section one hundred and eighty-one of the said Act there shall be substituted the following section:—

"181. No prosecution for any offence against the provisions of any of the five last preceding sections shall be taken except by a member of the police force under the written authority of the Chief Secretary or of the Minister of Public Health or of the Chief Commissioner of Police given either generally or in any particular case."

(d) At the end of sub-section (2) of section one hundred and eighty-two of the said Act there shall be inserted the words "given either generally or in any particular case"; and sub-section (3) of the said section one hundred and eighty-two is hereby repealed.

(2) Nothing in Part V. of the *Police Offences Act 1915* as amended by this Act shall relate to any work of recognised literary merit or to the printing or publishing or delivery or distribution or the posting or causing to be posted for transmission by post or to the having in possession for the purpose of distribution or for transmission by post for any lawful purpose of any *bonâ fide* medical or pharmaceutical

book pamphlet magazine or periodical; but in any prosecution for an offence under the said Part V. the burden of proof that a publication is a *bona fide* medical or pharmaceutical book pamphlet magazine or periodical or a work of recognised literary merit shall lie on the defendant.

Vital Statistics.

HOBART AND LAUNCESTON.

The returns of the births and deaths registered in Hobart and Launceston during the month of January, 1917, have been published by the Government Statistician. During the month 204 births, exclusive of those registered in accordance with the *Legitimation Act* and the *Births Amendment Act*, were registered in Hobart and Launceston. The birth-rate is equivalent to an annual rate of 37.92. The equivalent rate for Hobart was 42.48, and that for Launceston was 30.60 per 1000 of population. It appears that the birth rate has increased as compared with the average for the corresponding months of the previous five years.

The number of deaths registered in the two cities was 57. Of these, 31 took place in Hobart, and 26 in Launceston. The death-rate was equivalent to an annual rate of 10.56 per 1000 of population. The rate for Hobart was equal to an annual rate of 9.36, and that for Launceston was equal to one of 12.60. Of the total number, 23, or 40.34 per cent., took place in hospitals or other public institutions. The death-rate was lower than the average for January of the previous five years. Of the 57 deaths, 10 were of infants under one year of age. The infantile death-rate in Hobart was 28.36 per 1000 births, and in Launceston it was 92.69.

Concerning the causes of death, it is remarkable that the only infective diseases terminating fatally were tuberculosis (six cases), epidemic cerebro-spinal meningitis (one case), pneumonia (three cases), and diarrhoea and enteritis (six cases). No deaths were due to exanthemata. There were six deaths from malignant disease, three from organic disease of the heart, and two from cerebral hæmorrhage.

COUNTRY DISTRICTS OF TASMANIA.

The number of births registered during January, 1917, in the country districts of Tasmania was 322, which is equivalent to an annual birth-rate of 28.32 per 1000 of population. The number of deaths registered was 79, and the equivalent annual death-rate was 6.96. Of the causes of death but scant information is published. There was one death from dysentery, one from pulmonary tuberculosis, one from diabetes, and one from cancer. The death-rate was higher than the rate in January, 1915, and lower than that in January, 1916.

Obituary.

MALDWYN LESLIE WILLIAMS.

Maldwyn Leslie Williams, whose death from gunshot wounds was recorded in our issue of March 24, 1917, was born at Castlemaine, Victoria, on September 9, 1886. He was the sixth child and second son of Edward Davis Williams, for many years Municipal Councillor and Member of Parliament for Castlemaine, a man of sterling character and of strong public spirit. He was educated at the Castlemaine Grammar School and the Melbourne Church of England Grammar School. After matriculating at the latter he entered Trinity College, University of Melbourne, as a resident scholar in 1904 to read medicine. He held scholarships during his residence there. At the University he did excellent work throughout his course, ending well up in the Final Honour List, which placed him as resident surgeon to the Melbourne Hospital for the year 1909.

His work as a student was marked by the honesty and thoroughness of purpose which characterized all that he did. He was a general favourite with his fellow-students.

He was a fine sportsman, playing football for his schools, College and University, taking part in inter-school and inter-collegiate athletic contents, Melburnian hare and hounds, Trinity crew, etc.

On leaving the Melbourne Hospital he was offered and accepted the position of Assistant Surgeon at the Bendigo Hospital, under Dr. Walter Fowler. Here he found scope for his talents in surgery, and received the encouragement of the resident surgeon, who handed over to him plenty of work. When Dr. Fowler became seriously ill, Williams took his place, and when the former had finally to relinquish work, the Committee offered the position to Dr. Williams. He decided, however, to accept the partnership offered him by Mr. W. J. Long of the same city.

At the Hospital he developed to the full the kindly personality which endeared him to the staff and to the patients.

After a trip to the Far East in company with his mother and a sister he returned to Bendigo and active work. This lasted for three happy years. Whatever spare time he had was put into military matters. He had the formation of the Field Ambulance in connexion with the 67th Infantry, the training of the officers and men, and when he was going to the front it was a matter of great regret to his men, who had been waiting to go with him, that he was chosen for a unit consisting of men from the other States. He sailed in November, 1915, as Major, second in command of the 8th Field Ambulance. He went direct to Egypt, where he was situated in the desert, on the canal, and at "rail-head." Later he was transferred to France, and was at the front in the Pozieres action. Soon he was promoted to be Lieutenant-Colonel in command of the 1st Field Ambulance. His first and only leave from there was spent in England, where he visited his father's native place, Taterdig, North Wales, and saw relatives that he had not met before. On his leaving they lined up at the railway station and cheered him off.

His last letters from the front were full of cheerfulness and of good hope for a great reunion on his return. On March 3, 1917, he fell to a gunshot wound, and died on the same day.

He married in February, 1913, and leaves a widow and two daughters to mourn his loss. The younger daughter was born two weeks after he sailed. His loss is shared by his colleagues in Bendigo and the north, with whom he was on the best of terms, and with his patients, who became his friends.

Dr. Walter Fowler writes:—

Dr. Williams was a man of great natural abilities, far above the average. His chief characteristic was the facility with which he grasped the details and principles of anything he undertook. This faculty helped him enormously in his profession, for it enabled him to make a diagnosis sooner and more accurately than most men, and caused confidence in his judgement. In operating he was skilful and neat, bold when need be, but never reckless. He was a constant attendant at the meetings of our local Division of the British Medical Association, a frequent contributor to its proceedings and a keen debater. His clinical notes were always clear and interesting, because he took great pains in their composition.

He had made his mark in Bendigo, and a prosperous career was assured him. A ready welcome awaited his return; but it was not to be. One mourns a staunch and genial friend, and surgery loses an able exponent of the art.

Mr. W. J. Long writes:—

I first knew M. L. Williams when he was assistant to Dr. Fowler at the Bendigo Hospital, and when he took the latter's place. His bright personality, his straight, honourable manner, combined with the sterling quality of his work, attracted me always, and made it easy for me whom to ask when I decided to take a partner into my practice.

The three years we worked together were a pleasure to have lived through. No misunderstanding ever arose, and his kindly spirit was always striving to lighten the work for me.

I mourn for him as a brother.

HAROLD OSCAR TEAGUE.

Death, the inscrutable, had robbed the medical profession of another of its most valuable members, a man of unusual

integrity and uprightness. Harold Oscar Teague, as was recorded in these columns on March 17, 1917, was killed in action in France.

Teague was born in Bendigo on November 25, 1877. He received his schooling in that city, and later at Melbourne, where he attended the Brighton Grammar School. In due course he entered the Medical School of the Melbourne University, and graduated in Medicine and Surgery in 1901. He then spent a year in New Zealand, serving as resident at the Auckland Hospital. In 1903 he returned to Australia and settled in Western Australia, where he became assistant to Dr. W. Trethowan. He worked steadfastly and well for three years, and earned the affection and admiration of his chief. In 1907 he started practice in Victoria Park, where he soon gained the confidence of a large clientèle. As his practice grew, all the residents of Victoria Park learned to esteem the man for his unselfishness, his energy and inherent honesty of purpose and for his skill in dealing with his patients. It is said of him that his almost brusque truthfulness covered one of the kindest and most charitable dispositions imaginable. His popularity was not confined to his patients; his colleagues were proud of him, and in social life he was a general favourite. He was a keen tennis player and a good all-round sportsman.

He took an active part in the affairs of the Western Branch of the British Medical Association, served on the Council for several years and became its President in the year 1915-1916.

Early in the course of the war Teague prepared himself for service, and as soon as he was able to make arrangements he offered his services. His gazettal as Captain in the Australian Army Medical Corps, Australian Imperial Force, is dated May 1, 1915, but he appears to have been appointed to a position in the Corps some months prior to this date. He served with the No. 1 Australian General Hospital for a time, and was subsequently transferred to the Australian Forces, 11th Battalion. We have no detailed information concerning the manner in which he met his death while on active service.

By the irony of fate it seems as if just the men who can be spared least well are those who are chosen by the Great Leveller. Dr. Trethowan informs us that he has lost a close personal friend and one of the straightest and most honourable men he has ever had the good fortune to know. Many, many others mourn his death.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand London, W.C.

Branch.	APPOINTMENTS.
VICTORIA.	
(Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club
QUEENSLAND.	
(Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute

Branch.	APPOINTMENTS
SOUTH AUSTRALIA.	
(Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., incorp., Adelaide.
WESTERN AUSTRALIA.	
(Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES.	
(Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION.	
(Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

- Apr. 14.—S. Aust. Branch, B.M.A., Council.
Apr. 17.—N.S.W. Branch, B.M.A., Executive and Finance Committee; Ethics Committee.
Apr. 18.—W. Aust. Branch, B.M.A., General.
Apr. 18.—North Eastern Med. Assoc. (N.S.W.), Annual.
Apr. 19.—City Med. Assoc. (N.S.W.).
Apr. 20.—Q. Branch, B.M.A., Council.
Apr. 20.—Eastern Suburbs Med. Assoc. (N.S.W.).
Apr. 21.—Northern Suburbs Med. Assoc. (N.S.W.), Annual.
Apr. 24.—N.S.W. Branch, B.M.A., Med. Politics Committee; Organization and Science Committee.
Apr. 25.—Vic. Branch, B.M.A., Council.
Apr. 25.—Federal Committee of the B.M.A. in Australia, in Sydney.
Apr. 27.—N.S.W. Branch, B.M.A., Branch (Ordinary).
Apr. 27.—S. Aust. Branch, B.M.A., Branch.
May 2.—Vic. Branch, B.M.A., Branch.
May 4.—Q. Branch, B.M.A., Branch.
May 8.—Tas. Branch, B.M.A., Council and Branch.
May 8.—N.S.W. Branch, B.M.A., Ethics Committee.
May 10.—Vic. Branch, B.M.A., Council.
May 11.—N.S.W. Branch, B.M.A., Clinical.
May 12.—S. Aust. Branch, B.M.A., Council.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.
Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.
All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.

